Principles of Caregiving
Developmental Disabilities
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Developmental Disabilities

SECTION I — HISTORY & PHILOSOPHY OF SERVING PEOPLE WITH DEVELOPMENTAL DISABILITIES

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A. History

It is important that we learn about how people with disabilities have been treated by society in the past. Throughout history society treated people with disabilities very poorly. They were used as court jesters, locked up as criminals, abused and killed. Parents were told to "put them away, forget about them." To improve conditions for people with disabilities, society built large, hospital-like institutions. While these institutions were better than jail, they left a lot to be desired.

Video for viewing: *Unforgotten - Twenty-Five Years After Willowbrook*

The video you have just seen illustrates what the institutions were like. In Arizona these institutions were called "training programs" and these programs were located in Phoenix, Coolidge, and Tucson.

In 1977 there was a class action lawsuit that forced the state of Arizona to come up with alternatives to institutionalization. At first things moved slowly. Mini-institutions that housed 12 to 15 people in a home were established. Again, while this was an improvement, it was still very unfriendly and unaccommodating. Fortunately, Arizona and it's advocates for people with disabilities recognized this and pushed for even more change.

It is up to us to help create a bright future for individuals with disabilities. We are responsible for assisting in inclusion in the community, for doing our part to change the attitudes of others. As we go through this training we will learn more about the history and ways to pave the road to the future.

Philosophy

- Key Ideas/Terms
  - Social Role Valorization
  - Normalization
  - Dignity of Risk

Social Role Valorization
Having a valuable role in society
grow as a person

B. Philosophy

Today people embrace the ideas of normalization or social role valorization. This is the philosophy and policy that supports people with disabilities in the pursuit of lifestyles of their choosing. This means they have the right to a home, a career and recreational pursuits like others in their community. They also have the right to express themselves as individuals.

1. Social Role Valorization
Society views people differently and assigns a different value to people based on that view. For example, hundreds of years ago women were viewed as less valuable than men. They were not allowed to vote because of this lack of social value. It is our responsibility to help increase the value of people with disabilities in society. Some of the ways that we do this include community involvement and encouraging consumers to volunteer for social projects.

2. Normalization
Normalization means treating people how they want to be treated...a normal rhythm of the day. Providing people with choices, every person has the right to choose their own direction and their priorities. Our lives all look different, people choose their daily routines and those routines have meaning. You anticipate events, in the evening you think back on what you have accomplished. The day is not monotonous. Normalization is supporting individuals in **their** daily lives, the way they choose.

> Tip – ask the class what their morning looked like, what their weekend involved. This should demonstrate that no two people's lives look the same.

3. Dignity of Risk
This can be a very difficult thing for us to truly live up to. Let me explain dignity of risk by giving an example. When you have a child you will want to teach them to ride a bike. You know that while learning to ride a bike they are going to fall down and get hurt. You know that riding a bike also poses a lot of other dangers, like getting hit by a car, or getting lost away from home. Yet you teach the child to ride because of the benefits. Dignity of risk is knowing that someone could get hurt, physically, emotionally or financially, but allowing or encouraging them to go ahead and "do it" anyway. We will be faced with these types of situations on a daily basis when working with people with disabilities. We have to know when to step back and encourage them to "do it".

> Tip – ask the class for examples of dignity of risk. Some instructors choose to use video's to make this point – one example is Garth Brooks music video "Standing outside the Fire".

Philosophy Continued

- Key Ideas/Terms
  - □ Deinstitutionalization
  - □ Least Restrictive Alternative
  - □ Inclusion

"We need to belong intimately to a few people who are permanent elements in our lives. Only our relationships to other people endure."

Harold Kushner

4. Deinstitutionalization

What is deinstitutionalization? For many years it was common for people with Developmental disabilities to be placed in institutions, like the one in the Willowbrook video. Due to the often scandalous conditions found in many institutions, advocates for people with disabilities pushed for better care, this resulted in the deinstitutionalization process. Technically, deinstitutionalization refers to a planned reduction in the number of persons residing in institutions. When going through the process of deinstitutionalization common goals are; A.) Prevent new admissions to existing institutions. B) Return people with disabilities back to their community. C) Establish residential living arrangements in the community. D.) Promote public acceptance of people with disabilities. You would think that we would have achieved deinstitutionalization, but sadly even today people with developmental disabilities still reside in institutions. For some families they feel that institutions are the best options, or their child who is now an adult would not transition well to the community after a lifetime in an institution.

5. Least Restrictive Alternative

The concept of least restrictive alternative goes hand in hand with deinstitutionalization. The idea is that people should live their life with the least amount of restrictions placed upon them, that would allow for their well being. For example instead of living in an institution, the person could live in a home in the community with support from staff. This is a less restrictive environment. As the years have passed, "least restrictive alternative" has come to mean providing services in such a way that the person can experience as much freedom and personal empowerment possible. This means we even look at how we might help someone with a task or some sort of behavior management issue, we should explore options that are the least intrusive, the least controlling or demeaning. Usually for every problem there is more than one solution and it is our duty to promote the solution that empowers the person with disability. The least restrictive alternative solution is the one that favors or benefits the person served, not the caregiver.

6. Inclusion

What does it mean to be included, to be involved or in on the joke, or with the group, I think we can all say it means a lot. We all want to be included, as do people with disabilities, they do not want to be on the outside looking in, they, like us want to be in the middle of things. As we promote inclusion, people with disabilities are seen as a vital part of the community, giving them the opportunity for unlimited growth. Without this inclusion, nothing will grow or change. Including people with disabilities in social circles and community events allows them to develop meaningful relationships with others.

"We need to belong intimately to a few people who are permanent elements in our lives. Only our relationships to other people endure." HAROLD KUSHNER

Philosophy Continued

- Key ideas/terms
  - Sympathy vs. Empathy
  - Support Success
  - Relationships
  - Interactions
  - Individualization

7. Sympathy versus Empathy
- *Sympathy* means feeling sorry for someone – pity.
- *Empathy* means understanding what it is like for someone – putting yourself in their shoes.

It is important that we understand these concepts and keep them in mind when interacting with others.

8. Supporting Success
The first step to supporting a person to succeed is accepting and allowing failure to occur. This is how people learn. You must allow for challenge, risk, and growth within a learning opportunity. Ultimately, it is the relationship between the learner and the teacher that will ensure success.

9. Relationships
The relationship you build with people is vital to their growth. People with disabilities will not be valued for their uniqueness as long as they shop, recreate, work, and live in self-contained groups. Supporting individuality will help to change self-perceptions from a person who is dependent to one who is a responsible and singular citizen of the community. Ultimately, it is the relationship between the learner and the teacher that will ensure success.

10. Interactions
The interactions you have with the people with whom you support are tremendously important. These interactions should be a blend of professionalism and personal respect. This means that you need to use good judgment as you choose moments to teach as well as when you choose moments to provide support. Interactions involve your words, your tone, and the loudness of your voice, as well as your facial expressions and gestures. You should try to communicate in ways that fit the situation. Adults who respect one another do not refer to each other by labels, derogatory nicknames, or stereotypes. Nor do they act like a parent. Rather, they value people who communicate with them as peers in respectful ways.

Our appearance also conveys a message to others. How we dress and how we present ourselves in our jobs portrays what we think of our job as well as our opinion of people with disabilities. Dress should be appropriate to circumstances, but we should strive to model an enhancing appearance that others appreciate. This is as much true of ourselves as it is true for

persons who have disabilities. People are far more likely to be respected when they present an appealing appearance.

11. Individualization
We want to be treated as an individual, we don't want to be labeled or grouped with others. Why would people with disabilities be any different? Individualization is important. What surrounds us reflects our wishes, desires and tastes. This is what individualization is all about. We need to promote this concept so people with disabilities are seen as individuals.
Some of the ways to do this is to ensure that we uphold individual choice and preference in the following:
- ♦ Appearance and Dress
- ♦ Social-Recreation, Outside Relationships
- ♦ Community Involvement

Scenario for discussion: *You are in charge of a 32 year old man who uses a wheelchair. He resides in a group home where he lives. He wants to buy his dad a special Suns t-shirt for his birthday. The store where the t-shirts are located is quite a distance from the group home and has limited accessibility for wheel chairs. You know the trip would be difficult and tiring for him so you tell him that you'll pick it up on your way home that evening and bring it to him the next day. Are you showing empathy or sympathy? What would empathy look like?*

Communication with Families

- **Family Support Principles**
  - Respect family values, routines & priorities
  - Honor individual preferences
  - Help families find resources
  - Maintain confidentiality
  - Model valued behavior
  - Be a good listener

- **Effective Communication**
  - Positive , Professional & Supportive

12. Communication with Families

Communication with family members or for that matter communication with other staff, or DDD staff should always be professional and respectful. Families value direct communication. As a Direct Support Professional, you should be ready willing and able to speak directly with families. Communication is an important way of demonstrating family support principles.

Some of the **Family Support Principles** are:

- Respect family values, routines and priorities;
- Honor individual preferences
- Help families find the resources that they need
- Be a good listener
- Maintain confidentiality
- Model valued behavior

> Tip – remind staff they have gotten or will get more information regarding HIPAA. Additionally, they should be aware of who the responsible person has given staff permission to share information with.

The key to effective communication is to be:

Positive: Focus on the positive - what the person accomplishes not just the person's needs or issues. Celebrate success.

Professional: Talk *to* people not *at* them. Do not talk down to people. Use good language and be aware of your tone of voice (remember you are not their mother, father, etc.). Keep your personal life separate from your job.

Supportive: This is where empathy comes in. You have to be aware of how things are, not only for the person you support but for the person's family as well. One of the most effective things in being supportive is to be a good listener. A good listener looks at the person who is talking to them. They don't interrupt when others are talking. Repeat back parts of the conversation to ensure that you are on the same page (example: So what you're saying is...)

Models

- Developmental

- Self-Fulfilling

D. Models

1. Developmental
The developmental model is a change that occurred we deinstitutionalization first started. The institutions we based on a medical model, which lead people to view people with developmental disabilities as static and rather hopeless. This model placed an emphasis on limitations rather then potential. The developmental model is based on the idea that people with disabilities are capable of development, growth and learning. Each individual has the potential for progress. Developmental modeling involves teaching, demonstrating the proper technique, approach, or behavior. For example, serving meals "family style" teaches good eating habits and conversation skills. It means being a role model; being aware of how you interact with others. It is difficult to help someone learn a skill or behavior when the caregiver says one thing, then does another; likewise, it is much easier for someone to learn a skill or behavior when the caregiver says and actually does the same thing.

2. Self-fulfilling
People tend to act based on the way others expect them to act. The more we assume a person can do something, the more likely that the person will do it. Having expectations of ourselves and others gives us things to strive for, dream about and set goals towards. Having expectations can result in a self-fulfilling prophecy. This can be positive or negative; it is important that we set people up for success and see the potential in everyone. When we reduce our expectations, we reduce opportunities for positive experiences.

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SECTION II — INTRODUCTION TO DEVELOPMENTAL DISABILITIES

Education Outcome

■ The purpose of this module is to increase your knowledge of a few of the more common disabilities and how they may affect people.

The purpose of this training is to increase your knowledge of a few of the more common disabilities and how they may affect people. Please note this is not an all inclusive list and the information does not cover each and every aspect of a disability. The best way to support a person with a disability is to get to know them as a person.

Activity – *Ask the students to define the word disability. Post these answers on the blackboard or wall. Then say "It's great to see a large group of non-disabled people." At this time I would like to assign each of you to a specific group. Have cards numbered 1 through 10 posted around the room. When a statement is read ask the students to stand by the number corresponding to the statement that describes them. Read each of the following 7 statements. 1. Everyone who is wearing glasses or contacts move to station number 1. 2. Everyone who is left handed move to position number 2. 3. Everyone who does not know how to swim move to position number 3. 4. Everyone who is not bi-lingual move to position 4. 5. Everyone who does not own a computer go to position 5. 6. Everyone who does not have a college degree move to number 6. 7. Everyone that has had more then one of these statements apply to them move to position 7. Ask the students to think about their feelings or reactions to being labeled.*

Background

- People first

- Be careful of Labels

- Criteria for Service

- Resources

A. Providing Support

1. People First

As we go through this class you will be provided with information regarding specific disabilities. You must realize that a disability does not define a person, just as a cultural background does not define a person. We need to be sensitive to cultural beliefs and philosophies. We have to see the person first – just as we want to be seen. A person with a disability has their own desires, needs and emotions just like anyone else. Their feelings do not change because of a disability. We have to treat each person as an individual.

2. Avoid Labels

Labels make us think everyone with the label is alike. The people we serve have labels just like all of us. When a person is called mentally retarded, or mentally ill, we have a certain image of him or her. But each individual with a disability is a unique person with his or her own dreams, goals, and needs just like everyone else. Labels make us predict that people will act in certain ways. People tend to act based on the way others expect them to act. The more we assume a person cannot do something, the more likely that the person will have trouble doing it.

> Tip – give the class time to discuss and provide examples of labeling.

 A disability can become a label – it is up to us to prevent that from being the case. Always refer to the person you are working with by name, not disability. It is important when providing information to other caretakers that we describe the person, again not the disability. Additionally, disabilities affect everyone differently and we cannot and should not use this information presented today as the only window to how we view people.

Many of the people you may be providing services for became eligible for those services by virtue of their disability or the manner in which a disability affected them. For instance, people who receives services through the Division of Developmental Disabilities must be diagnosed with one of the following qualifying conditions: autism, cerebral palsy, epilepsy or mental retardation (cognitive disability). Other organizations providing services will have different criteria for determining who is eligible for services.

Explain—*With labeling we need to say the person first ie. The correct way is, she is a child with Down syndrome, not she is a Down's child. Just as you wouldn't say she is "a blonde", so you avoid the label of blonde describing the person's intelligence. You may say she has blonde hair if you need to give a description.*

Physical Disabilities

- What is a physical disability?
  - □ It is an impairment that causes difficulty with mobility.
- What are the symptoms?
  - □ Inability to gain access to a building or room
  - □ Decreased eye-hand coordination
  - □ Impaired verbal communication
  - □ Decreased physical stamina and endurance
- What is the cause?
  - □ Congenital, result of injury, muscular dystrophy, multiple sclerosis, cerebral palsy and others

B. Physical Disabilities

Physical disabilities refer to a broad range of disabilities which include orthopedic, neuromuscular, cardiovascular and pulmonary disorders. People with these disabilities may utilize assistive devices such as wheelchairs, crutches, canes, and artificial limbs to obtain mobility.

Symptoms

Although the cause of the disability may vary, persons with physical disabilities may face the following difficulties:

Inability gaining access to a building or room; Decreased eye-hand coordination; Impaired verbal communication; Decreased physical stamina and endurance; Any inability to use their large muscles to complete a task or activity.

Cause

The physical disability may either be congenital (from birth) or a result of injury, muscular dystrophy, multiple sclerosis, cerebral palsy, amputation, heart disease, pulmonary disease or more. Some persons may have hidden (nonvisible) disabilities which include pulmonary disease, respiratory disorders, epilepsy and other limiting conditions.

Activity—*have students "experience" a physical disability. For example, have them experience what it is like to move around the building in a wheelchair.*

Providing Support

- A wheelchair or other assistive device is part of that person's body space – be respectful of that.
- Don't be afraid to use words like walk or run.
- Ask before helping.
- Don't be afraid to ask someone to repeat themselves.

Supporting people with physical disabilities

If a person uses a wheelchair, conversations at different eye levels are difficult. If a conversation continues for more than a few minutes and if it is possible to do so, sit down, kneel, or squat and share eye level.

A wheelchair is part of the person's body space. Do not automatically hang or lean on the chair; it is similar to hanging or leaning on the person. It is fine if you are friends but inappropriate otherwise.

Using words like "walking" or "running" are appropriate. Sensitivity to these words is not necessary. People who use wheelchairs often use the same words.

When it appears that a person needs assistance, ask if you can help. Most persons will ask for assistance if they need it. Accept a "no thank you" graciously. Provide assistance if you are asked. Never come up behind a person who uses a wheelchair and push them. Always ask first while facing the person. Never take the door out of a person's hand to assist them in opening it, they may be using the door for balance. Always ask if you can help first.

Accept the fact that a disability exists. By not acknowledging this fact it is the same as not acknowledging the person.

People with physical disabilities are not "confined" to wheelchairs. They often transfer over to automobiles and to furniture. Some who use wheelchairs can walk with the aid of canes, braces, crutches or walkers. Using a wheelchair some of the time does not mean an individual is "faking" a disability. It may be a means to conserve energy or move about more quickly.

Deaf or Hearing Impairments

- What is deaf or hearing impaired?
  - The inability to hear or difficulty hearing or discriminating between sound and speech
- What are the symptoms?
  - It is difficult to gain the person's attention
  - They ask you to repeat things often
- What is the cause?
  - Hearing loss or deafness can be genetic, environmental, a result of injury or illness and others

C. Impairments

1. Hearing
Hearing impairment or deafness is the inability to hear or distinguish between sound and speech.

What are the symptoms?
Some people may tell you they have a hearing loss, for others you may observe that they wear a hearing aid. It may be difficult to get the attention of someone with a hearing difficulty or they may ask you to repeat things. Rarely is a person completely deaf, and a hearing loss could fall anywhere along the continuum from totally deaf to hearing. The amount of usable (or residual) hearing varies greatly from person to person. Depending upon the type of loss, the person may or may not benefit from the amplification that a hearing aid provides. Hearing aids only amplify sound, they do not make sound clearer. The severity of a person's hearing loss could be different at various frequencies. Therefore, ability to hear different voices will vary depending on a number of factors, including the pitch of the voice.

What is the cause?
Hearing loss or deafness has several causes. Hearing loss can be genetic, environmental – exposure to loud noises for prolonged periods of time, a result of an injury or illness and other causes.

Providing Support

- Communication is the life activity most affected by hearing impairments
- Get to know the person and how they communicate
- Utilize a variety of techniques including; pen & paper, sign language, gestures, communication devices, finger spell and other methods used by the person

The life activity most affected by hearing loss is communication.   Get to know the person you are supporting, learn how they communicate. You can use a variety of techniques to communicate with someone with a hearing difficulty. Pen and paper are handy communication devices in some situations. Although you want to avoid gross or exaggerated arm waving, pantomime is helpful. Be aware that if you point to an object or area during a conversation with a person who is deaf or hard of hearing, that person will most likely turn to look at where you are pointing. Allow their gaze to return to you before continuing with what you are saying. Though not effective for all people who are hearing impaired, knowing some sign language and finger spelling is helpful. Learn some elementary or survival signs from colleagues, coworkers, or managers who are deaf or hard of hearing.

Attention Getters
Getting the attention of someone who is deaf or hard of hearing can vary depending on the person and the situation. If the person has enough residual hearing to pick up a verbal cue, calling their name is quite appropriate. When this does not work and the person is within reach, a light tap on the shoulder or lightly placing your hand on their shoulder works well. A heavy touch and rapid tapping is used to indicate urgency, such as during an emergency. Sometimes hitting your foot on the floor repetitively or light pounding on a table are used. The latter works especially well when the person who is hearing impaired is leaning on the table. For getting the attention of large groups, simply flash the lights in the room on and off several times at a slow and steady pace. This works well in mixed groups of deaf and hearing people. Again, rapidly flashing the lights indicates an emergency.

Lip Reading
Not all hearing impaired people are good lip readers and lip reading skill has no correlation to a person's intelligence. Even good lip readers may miss many words. Keep in mind that only 25-30% of spoken English can be lip read. Not all deaf people know how to speak sign language, or choose to use sign language interpreters. When a person is reading your lips, enunciate clearly, but do not yell or over enunciate your words, as you will distort your lip movements and also look very foolish. Remove from your mouth objects such as cigarettes, pipes, gum, chewing tobacco, or food. Keep your hands or any other objects from covering your mouth. A beard or mustache may interfere with a lip reader's ability to read your lips. Try to sit with a light source in front of you, not behind you (such as a window).

Speech
Many people who are deaf or hard of hearing have voices that are easily understood. Others cannot monitor the volume and tone of their speech and may be initially hard to understand. If a person is speaking for themselves and you do not understand their speech, it is appropriate for you to ask them to repeat, or even to write down what is being said. Ask in a respectful, not condescending manner. Deaf people, like hearing people, vary to some degree in their communication skills.

Sign Language
For many people who speak sign language, American Sign Language (ASL) is the first language that they acquire and use. ASL is a recognized language with a unique syntax, grammar, and structure. It is not a form of English. Other people who use sign language that is not ASL use one of the manual codes for English that combines some of the vocabulary of ASL signs with some of the grammar and syntax of English.

Phone Calls
Relay services establish communication between hearing people who use voice phones and hearing or speech impaired people who use Telecommunication Devices for Deaf (TDD). The Americans with Disabilities Act mandates that every state establish such a service for both in-state and out-of-state calls.   If you wish to contact a deaf person using your local relay service, call the voice number and give the operator the deaf person¹s TDD number. If you are deaf and trying to contact a voice number with your TDD, call the TDD number and give the operator the voice number.

Visual Impairments

- What is a visual impairment?
  - Inability to see or inability to see clearly
- What are the symptoms/signs?
  - Squinting, difficulty seeing, headaches, difficulty with depth perception
- What is the cause?
  - Can be genetic, degenerative, a result of a medical condition, or accidental

2. Visual

Inability to see or inability to see clearly. The ability to see may exist anywhere along a continuum from sighted to blind. In addition, the amount of usable sight varies from person to person, and visual acuity may change under differing light conditions.

What are the symptoms/signs?
Squinting, difficult seeing, headaches, difficulty with depth perception.

What is the cause?
Can be genetic, degenerative, a result of a medical condition, and accidental.

Activity—*Have students take turns being blindfolded and have other students lead them around. Cue them to give verbal instructions*

Providing Support

- Announce your presence
- Use a normal tone of voice
- Remember, people use sound for orientation
- Use descriptive words about the location of things, steps, and other terrain changes
- If walking let the person take your arm
- Don't pet or touch a guide dog without permission

Announce your presence and who you are in a normal tone of voice. When you leave a person's presence, say so.

It is not necessary to speak more loudly when conversing with someone with a vision impairment. However, you should not stop talking when a person with a visual impairment is approaching you because he/she may rely on the sound of your voice for orientation. When giving directions, use descriptive words such as straight, forward, left. Be specific and avoid the use of vague terms such as "over there." Feel free to use words like "see" or "look" when speaking to a person with a visual impairment.

If you are walking with a person with a visual impairment, let them take your arm from behind just above the elbow and walk in a relaxed manner. In this position, the person can usually follow the motion of your body. When you take their arm, the person does not have the advantage of following your movements. Be sure to provide visual cues for things such as stairs and other obstacles in their path. If there are others in a room that you enter, the individual may not be aware of this. Introduce each person by name and indicate where they are in the room relative to where the person with a visual impairment is located.

Guide dogs are working animals. There is a special relationship between the person who is blind and their dog. When working, it can be hazardous for the person with vision impairment if the dog is distracted. **NEVER** pet or touch the dog without obtaining permission.

Speech Impairments

- What is a speech disability?
  - Inability to speak clearly
- What are the symptoms?
  - Difficulty with voice strength, fluency, aphasia (word processing problem) which may alter articulation or voicelessness
- What is the cause?
  - Congenital, or due to illness or injury
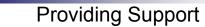
3. Speech

Speech impairments vary in type and degree. Some may include difficulty with voice strength, fluency, aphasia - which may alter the articulation of certain words, or voicelessness.

Occurrence of speech impairments may be congenital, or due to an injury or illness.

Activity: Give each student 10 crackers and have them read a statement with their mouth full. This exercise helps students understand how frustrating it can be to speak and not be understood when you have a speech impairment.

Providing Support

- Be patient
- Be a good listener
- Encourage self expression
- Encourage use of assistive devices
- Allow one-on-one communication
- Be familiar with communication boards, symbols, and sign language
- Model correct speech

The key to interacting with a person with a speech related disability is patience. It is in no one's best interest to pretend you understand someone if you do not. Repeat what you understand, and allow the individual the time to "fill in the blanks." The following is a list of other considerations to keep in mind through your interactions:

Be patient and allow the person to complete what they are saying without interruption.

Wait … do not assist unless you are asked.

Be a good listener.

Encourage self-expression, but do not pressure the person to speak.

Allow the use of assistive devices such as "speaking machines" or computerized synthesizers.

Anxiety can aggravate a speech disability.

Do not insist that someone with a speech related disability talk in a group.

Allow one-on-one communication if necessary.

Communication boards, symbols, and cards for commonly used words greatly aid persons who have difficulty with speech.

Always use good speech so that the other person can hear how words should be said and used.

Autism

- What is Autism?
  - □ Developmental disorder of the brain
- What are the symptoms?
  - □ Impaired social interaction
  - □ Problems with communication
  - □ Unusual responses to sensory stimulation
- What is the cause?
  - □ No single cause, may be environmental or congenital

D. Autism

Autism is not a disease, but a developmental disorder of brain function. Autism varies a great deal in severity. The most severe cases are marked by extremely repetitive, unusual, self-injurious, and aggressive behavior. This behavior may persist over time and prove very difficult to change, posing a tremendous challenge to those who must live with, treat, and teach these individuals. The mildest forms of autism resemble a personality disorder and learning disability.

Tip -
Autism is one of the qualifying diagnoses for services through the Division of Developmental Disabilities. Note: This does not include other diagnoses on the autism spectrum.

What are the symptoms?
Impaired social interaction, - The most obvious symptom of autism is impaired social interaction. Children with autism may fail to respond to their names and often avoid looking at other people. They often have difficulty interpreting tone of voice or facial expressions and do not respond to others' emotions or watch other people's faces for cues about appropriate behavior. They appear unaware of others' feelings toward them and of the negative impact of their behavior on other people.

Problems with communication - problems with verbal and nonverbal communication, and unusual or severely limited activities and interests.

Unusual responses to sensory stimulation - Many children with autism engage in repetitive movements such as rocking and hair twirling, or in self-injurious behavior such as biting or head-banging. People with autism often have abnormal responses to sounds, touch, or other sensory stimulation. Many show reduced sensitivity to pain. They also may be extraordinarily sensitive to other sensations such as light, sound or touch. These unusual sensitivities may contribute to behavioral symptoms such as resistance to being cuddled.

What is the cause?
No single cause, may be environmental or congenital.

Activity: *Have one student pretend to be the person with Autism. Have them sit in a chair in the front of the room. Have another student stand behind this person and rub up and down on their neck with a feather – this represents the tag on the back of the person's shirt. Have another student stand to the side of them and hum – this represents the buzzing they may hear from florescent lights. Have another student stand to one side and read aloud from a book – this represents other noise they may hear in their environment. Have the instructor stand in front of the person and give them direction.   The overall point of the exercise is to point out how many distractions their may be in the persons environment that makes it hard for them to respond to what is going on.*

Providing Support

- Provide clear verbal instruction

- Be sensitive to the environment: sound, light and touch

- Provide opportunities for movement

When providing support to people with Autism it is best to provide clear simple verbal instructions. Use their name to get their attention and then give the instruction or direction.

Be aware of offending noises and materials in the environment. People with Autism tend to be sensitive to sound, light and touch. Watch for noisy, over stimulating places.

Sometimes motion is soothing to people with Autism. Help them find ways to meet their need for motion – swings, trampolines, rocking chairs. This motion can help them stay centered.

Mental Retardation/ Cognitive Disability

- **What is Mental Retardation/Cognitive Disability?**
  - Below average IQ
  - Rate of learning much slower than average
  - Some limitations in daily living skills

- **What is the cause?**
  - Down Syndrome
  - Fetal Alcohol Syndrome,
  - Fragile X
  - Environmental Factors – head injury, stroke, complications during delivery, ,and certain infections

E. Mental Retardation/Cognitive Disability

Mental retardation is characterized both by a significantly below-average score on a test of mental ability or intelligence and by limitations in the ability to function in areas of daily life, such as communication, self-care, and getting along in social situations and school activities. People with mental retardation tend to learn at a slower rate than average person, yet they are able to progress.

Note: At this time the medical term continues to be mental retardation. Arizona has joined a national movement to use the term Cognitive Disability in place of Mental Retardation.
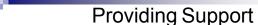
Tip - Mental Retardation is one of the qualifying diagnoses for services through the Division of Developmental Disabilities.

What is the cause?

Mental retardation can start anytime before a child reaches the age of 18 years. It can be caused by injury, disease, or a brain abnormality. These causes can happen before a child is born or during childhood. Some of the most common known causes of mental retardation are: Down syndrome; Fetal alcohol syndrome; and Fragile X syndrome.

The majority of instances of mental retardation are genetic and occur before birth. Some cases of mental retardation are caused after birth by environmental factors such as head injury, stroke, and certain infections such as meningitis.

The effects of mental retardation vary considerably among people, just as the range of abilities varies considerably among people who do not have mental retardation. Most will be mildly affected and will be a little slower than average in learning new information and skills. Some people with mental retardation may experience other diseases and conditions such as seizures, deafness, etc.

Providing Support

- Provide clear verbal instruction

- Get to know the person you support – know their strengths and desires

- Provide opportunities for growth

- Model correct behavior and techniques and encourage independence

Get to know the person you support – Just like anyone else, the people who are most supportive to us are our friends and family – develop that relationship.

Provide clear verbal instructions - It is best to provide clear simple verbal instructions. Use the name of the person to get their attention and then the instruction or direction.

Provide opportunities for growth – Don't assume that because someone has a disability they cannot do things for themselves. Encourage the person to try new things and to do tasks with as little assistance as possible.

Model correct behavior - the person will learn from watching you. Use proper behaviors so the individual can follow. Sometimes a task or behavior must be repeated many times until the person learns it. Be patient and positive.

Many people will need assistance in learning and in other areas. They may be accessing physical, occupational and speech therapy services. Always speak clearly and follow through with any activities provided by the therapist. Supporting therapy goals through informal or formal practice of goals is essential.

Use a consistent approach when doing behavioral interventions – consistency provides a sense of security.

Be aware of how the environment affects the person you are supporting. Some people tend to be sensitive to sound, light, and touch.

Plan for transitions – changes can be difficult, by giving cues about the change ahead of time the transition from one activity to another will go smoother. Transitions are difficult for many people with a disability regardless of what the disability is.

Encourage people, within the limits of safety, to be independent and participate in activities with people without disabilities. If a child, encourage to participate in classroom activities.

Parenting a child with a disability is full of challenges. Support groups are a good resource for many parents. Counseling can also support parents and siblings, in understanding and managing the daily issues related to having a family member with a disability. As a Direct Support Professional, you can assist the family by ensuring that their loved one is well taken care of.

Down Syndrome

- **What is Down Syndrome?**
  - A genetic disorder that causes mental, and sometimes, physical impairments
- **What is the cause?**
  - An error in cell division at conception, resulting in an extra 21st chromosome
- **What are the symptoms?**
  - Low muscle tone
  - Speech difficulties
  - Flat facial profile and short stature
  - About ½ of all people with Down syndrome will have congenital heart defects
  - Mental retardation

F. Syndromes

1. Down Syndrome

DS is a genetic disorder that causes mental retardation/cognitive disability. It also can cause physical impairments that can affect a person's ability to use his/her small and large muscles correctly.

What causes Down Syndrome? Down syndrome is caused by an uneven cell division in the fertilized egg. All people with Down syndrome have an extra, number 21 chromosome present in all, or some, of their cells. This additional genetic material alters the course of development and causes the characteristics associated with the syndrome.

What are the symptoms?
There are many physical characteristics that help identify a person with Down syndrome. Some people with Down syndrome have only a few of these traits, while others have many. Among the most common traits are:

Low muscle tone

Flat facial profile, a somewhat depressed nasal bridge and a small nose

Upward slant to the eyes

Enlargement of tongue which may effect speech

Short stature

Other concerns: Almost half of all people with Down syndrome have congenital heart defects. Most people with Down syndrome will have some degree of mental retardation/cognitive disability.

Providing Support

- Remember that everyone is unique
- Support activities that build muscle tone
- Be aware of health issues
- Encourage appropriate social skills model correct behavior
- Provide support with therapy and learning goals

Remember everyone is unique and that includes people with Down Syndrome. The best way to support anyone regardless of their disability is to get to know the person. What they like and dislike, their communication skills and their health issues.

Support activities that build muscle tone - encourage physical activity unless there are health reasons that prohibit physical activity.

Encourage correct social skills – sometimes folks with Down Syndrome can be very friendly and may need help developing boundaries.

Be aware of health issues, many people with Down Syndrome are susceptible to heart and breathing problems. Never put a person with Down Syndrome in a position that compromises their breathing.

Fragile X

- What is Fragile X?
  - A genetic disorder which causes a wide range of mental impairments, from mild learning disabilities to severe mental retardation.
- What is the cause?
  - A genetic abnormality
- What are the symptoms?
  - Tactile defensiveness
  - Perseverative speech (repeating the same words)
  - Hyper extensible joints (double jointed)

2. Fragile X Syndrome

Sometimes also called Martin-Bell syndrome, Fragile X is a genetic disorder and is the most common form of inherited mental retardation. Males afflicted with this syndrome typically have a moderate to severe form of cognitive disability. Females may also be affected but generally have a mild form of impairment.

What is the cause?
It is a sex-linked genetic abnormality in which a mother is a carrier, transmitting the disorder to her sons. It affects approximately 1 in every 1,000 to 2,000 male individuals, and the female carrier frequency may be substantially higher.

What are the symptoms?
Fragile X syndrome affects individuals in a wide variety of ways. Some individuals experience significant challenges because of the effects of Fragile X, while the impact on others is so minor that they will never be diagnosed.

> Tactilely defensive = having a negative response to touch
> Perseverative speech = continued repetition of words or phrases
> Hyper extensible joints = double jointed

Providing Support

- Support speech/language therapy activities
- Use a consistent approach when doing behavioral interventions
- Provide clear verbal instruction
- Be sensitive to the environment
- Plan for transitions

Individuals with Fragile X Syndrome are more likely to have difficulties with communication. Support speech/language therapy activities.

Be sensitive to the environment - be aware of offending noises and materials in the environment. People with Fragile X Syndrome are more likely to be sensitive to sound, light and touch. Watch for noisy, over stimulating places.

Fetal Alcohol Syndrome

- What is Fetal Alcohol Syndrome (FAS)?
  - FAS is a lifelong set of physical, mental and neurobehavioral birth defects
- What is the cause?
  - Alcohol consumption during pregnancy.
- What are the symptoms?
  - Growth deficiencies
  - Skeletal deformities
  - Facial abnormalities
  - Organ deformities
  - Central nervous system impairments

3. Fetal Alcohol Syndrome (FAS)

FAS is a lifelong, yet completely preventable set of physical, mental and neurobehavioral birth defects. FAS is the leading known preventable cause of mental retardation/cognitive disability and birth defects.

What is the cause?
Consumption of alcohol prior to conception by either the father or the mother, and or consumption by the mother during pregnancy.

What are the symptoms?
Some people with FAS have only a few of these traits, while others have many. Among the most common traits are:

Growth deficiencies: small body size and weight, slower than normal development and failure to catch up.

Skeletal deformities: deformed ribs and sternum; curved spine; hip dislocations; bent, fused, webbed, or missing fingers or toes; limited movement of joints; small head.

Facial abnormalities: small eye openings; skin webbing between eyes and base of nose; drooping eyelids; nearsightedness; failure of eyes to move in same direction; short upturned nose; sunken nasal bridge; flat or absent groove between nose and upper lip; thin upper lip; opening in roof of mouth; small jaw; low-set or poorly formed ears.

Organ deformities: heart defects; heart murmurs; genital malformations; kidney and urinary defects.

Central nervous system handicaps: small brain; faulty arrangement of brain cells and connective tissue; mental retardation -- usually mild to moderate but occasionally severe; learning disabilities; short attention span; irritability in infancy; hyperactivity in childhood; poor body, hand, and finger coordination.

Providing Support

- Provide clear verbal instruction
- Get to know the person you support
- Provide opportunities for growth
- As in other disabilities, be aware of sensitivity to the environment and encourage independence

Routines may be very important for an individual with FAS.

Like all disabilities, FAS affects people in a variety of ways. Each person's needs are unique, particularly if they have FAS.

Cerebral Palsy

- **What is Cerebral Palsy?**
  - □ Cerebral palsy (CP) is a group of motor problems and physical disorders. CP affects the muscles of a part or side of the body, sometimes the entire body. Uncontrolled reflex movements and muscle tightness (spasticity) occur with varying severity.
- **What are the symptoms?**
  - □ Problems with body movement and posture, although the degree of physical disability varies
- **What is the cause?**
  - □ The brain may fail to develop normally when it is deprived of blood, oxygen, or other nutrients. An infection or accident may also injure the brain

G. Cerebral Palsy

(CP) is a group of motor problems and physical disorders that result from a brain injury or abnormal brain development that may occur during fetal growth, at the time of birth, or within the first 2 or 3 years of a child's life. Although permanent, the brain abnormality does not get worse over time. CP affects the muscles of a part or side of the body, sometimes the entire body. Uncontrolled reflex movements and muscle tightness (spasticity) occur with varying severity.

What are the symptoms of cerebral palsy?

Everyone with cerebral palsy (CP) has problems with body movement and posture, although the degree of physical disability varies. Some people with CP have only a slight limp or an uncoordinated walk. Others have little or no control over their arms and legs or other parts of their body, such as their mouths and tongues. People with severe forms of cerebral palsy may have other health concerns in addition to their CP, including seizure disorders and mental retardation/cognitive disability.

Babies born with severe CP may have a floppy or very stiff body. Birth defects such as an irregularly shaped spine, small jawbone, or small head sometimes occur along with cerebral palsy.

It may seem as though CP gets worse over time because some symptoms don't appear until the nervous system matures. This is why some babies born with CP do not show obvious signs right away.

> Tip: Remind class that CP is not the only diagnosis that overlaps with other disabilities. This is true for all people; we all can have a variety of health concerns.

What causes cerebral palsy?

The brain may fail to develop normally when it is deprived of blood, oxygen, or other nutrients. An infection or accident may also injure the brain. Although the exact cause usually is difficult to determine, brain injury related to prematurity often is involved.
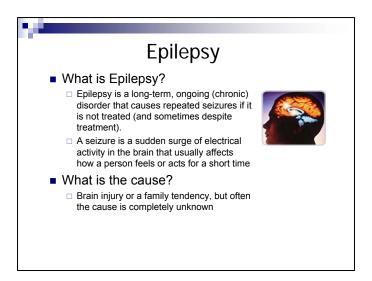
Providing Support

- Support medication schedules
- Encourage physical, speech and other therapy goals
- Be supportive of the family
- Help families and individuals maintain a combination of optimism and realism

How is cerebral palsy treated?

Cerebral Palsy (CP) does not get worse over time. Treatment focuses on managing symptoms, sometimes with medications, and maximizing abilities with physical therapy and other special training. People with CP may need special health care throughout their lives to prevent or treat complications.

Epilepsy

- **What is Epilepsy?**
  - □ Epilepsy is a long-term, ongoing (chronic) disorder that causes repeated seizures if it is not treated (and sometimes despite treatment).
  - □ A seizure is a sudden surge of electrical activity in the brain that usually affects how a person feels or acts for a short time
- **What is the cause?**
  - □ Brain injury or a family tendency, but often the cause is completely unknown

H. Epilepsy

Epilepsy is a long-term, ongoing (chronic) disorder that causes repeated seizures if it is not treated (and sometimes despite treatment).

A seizure is a sudden surge of electrical activity in the brain that usually affects how a person feels or acts for a short time. Seizures are not a disease in themselves. Instead, they are a symptom of many different disorders that can affect the brain. Some seizures can hardly be noticed. Others may involve the entire body, and affect a person in many aspects of their life.

Tip: Epilepsy is one the qualifying diagnoses for services through the Division of Developmental Disabilities.

Before a diagnosis of epilepsy is made a person must have had at least two seizures that were not caused by some known medical condition like alcohol withdrawal or extremely low blood sugar. The seizures in epilepsy may be related to a brain injury or a family tendency, but often the cause is completely unknown. The word "epilepsy" does not indicate anything about the cause of the person's seizures or how severe they are.

Providing Support

- **When a seizure occurs:**
  - □ **Keep calm**. Remember that there is nothing you can do to stop a seizure once it has started, but there are things you can do to help:
  - □ Protect the person from getting hurt.
  - □ Do not interfere or try to stop the seizure.
  - □ Once the seizure is over, turn the head to the side.
  - □ Provide support after the seizure.

Appropriate response to seizure activity~ Observing a seizure can be alarming. If a person has a grand mal seizure, the main rule is to **keep calm**. Remember that there is nothing you can do to stop a seizure once it has started, but there are things you can do to help:

1. Protect the person from getting hurt. Do not try to hold the person down, but clear the immediate area.

2. Do not interfere or stop the seizure. Do not try to open the mouth or put anything inside the mouth. A person is unlikely to swallow his or her tongue.

3. Once the seizure is over, turn the person's head to the side. If you can turn the person's head without too much strain, it will allow saliva to drain out of the mouth. Only do this if you can do it gently.

4. Provide support after the seizure. Each person responds differently to a seizure. The most common reaction after a seizure is that a person may be tired and may need to rest. While recovering from a seizure, a person may have difficulty eating or drinking, so it is best not to provide food or drink until he or she is fully recovered. Reassurance, a quiet word, respect, comfort and a chance to sleep are the best things to provide. Other people may feel energized, "wired," show signs of psychosis, or have no reaction. People respond in a variety of ways.

Spina Bifida

- What is Spina Bifida?
  - □ An opening in the spine
- What are the symptoms?
  - □ Paralysis or muscle weakness
  - □ Difficulty with bowel or bladder control
  - □ Hydrocephalus
- What is the cause?
  - □ No definite cause
  - □ Low levels of folic acid in the mother prior to birth
  - □ High fever during early pregnancy

I. Spina Bifida

Spina Bifida occurs when a person is born with an opening in the spine. A healthy spine is closed to protect the spinal cord, a bundle of nerves that send messages back and forth between your brain and the rest of your body. Because of this opening in the spine, the nerves of the spinal cord may be damaged. The messages carried by the spinal cord may not get through to the brain. Spina Bifida occurs in one out of every one thousand births.

Symptoms:
This can result in paralysis or muscle weakness below the area of the spine where the incomplete closure (or cleft) occurs. Sometimes there is a loss of sensation below the cleft, and loss of bowel and bladder control. In addition, fluid may build up and cause an accumulation of fluid in the brain (a condition known as hydrocephalus). Some people with Spina Bifida may have learning problems, but most have normal intelligence.

Cause:
The cause of Spina Bifida is unknown, however research has shown that if a woman takes 400 mg of folic acid every day before becoming pregnant that she can reduce her risk of a having a baby with Spina Bifida or other neural tube defect by up to 70%. Women who have a high fever early in pregnancy may also be at a higher risk of having a baby who has Spina Bifida.

Providing Support

- Surgical intervention
- Provide flexible supports to meet medical needs.
- Help develop and implement bladder or bowel programs.
- Encourage early intervention for cognitive delays
- Support independence.
- Help develop mobility skills
- Adapt the environment.

Although there is no cure for Spina Bifida, there are surgical procedures that are done to close the spine.   The person sometimes needs additional surgery on the feet, hips or spine. For those affected with hydrocephalus a tube or shunt is surgically inserted to drain the extra fluid from the brain.

Provide flexible supports to accommodate or support any medical procedures that may need to be done.

Help with the development or implementation of a bladder and bowel management program. This could include regular bathroom trips, catheterization (insertion of a tube to permit passage of urine), or wearing protective under garments.

In some cases children with Spina Bifida can have learning problems. Provide support to pay attention and help with expressive language skills. Early intervention for these and math and reading difficulties can help considerable.

Provide support and encouragement in the development of mobility skills such as learning to use wheel chairs, crutches or braces.   Look for ways to adapt the environment to accommodate any physical mobility difficulties.

Mental Illness/Emotional Disabilities

- **What is serious mental illness?**
  - □ Serious psychological disabilities

- **What are the symptoms?**
  - □ Mood swings, withdrawing from others, responding to things that are not there

- **What is the cause?**
  - □ Structural and biochemical differences in the brain
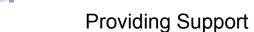
J. Serious Mental Illness/Emotional Disabilities

SMI and Emotional Disabilities include **s**chizophrenia and mood disorders (such as bipolar and clinical depression) are the two most prevalent forms of serious psychological disabilities. There are many mental illnesses or emotional disabilities such as: Depression, Bi-Polar Disorder, Anxiety, Schizophrenia and others.

Some of the more common symptoms are mood swings, withdrawing from others, responding to things that are not there.

Cause
People with serious psychological disabilities have some structural and biochemical characteristics in their brains that are different from those of people who are not mentally ill. Psychological disabilities are usually, although not always, a chronic disease.

Providing Support

- Realize that this disability is not a matter of choice
- Encourage compliance with medication protocols
- Follow instructions of professional counselor
- Dispel common myths

It is important for those around this person to realize that this type of disability is biological and not "a matter of choice."
Encourage compliance with medication protocols.
While no cure has yet been found, the symptoms can often be controlled with medication and other treatment methods. Psychological disabilities are moderated through medications much like someone with diabetes.
Remember to always follow instructions from the counselor or psychologist who oversees the person's care.

Myth: People who are mentally ill should just pull themselves together and think positively.
Fact: Serious mental illnesses are brain disorders over which people have little or no control. New research shows that both the structure and the functioning of the brain in those with a mental illness are different than in well individuals.

Myth: A person with schizophrenia has multiple personalities.
Fact: Schizophrenia is a disorder of the brain that changes the way people think. "Split" or multiple personality disorder is a different and very rare form of mental illness.

Myth: Mental illness is caused by family stress or other life traumas.
Fact: Serious mental illness is not the product of "bad parenting", although stress may have an influence on when it appears.

Myth: People with mental illness are dangerous and violent.
Fact: People with mental illness are no more violent than the general population. The disease exaggerates and distorts the personality. It does not change peaceful people into violent ones.

ADHD/ADD

- **What is attention deficit hyperactivity disorder (ADHD)?**
  - A group of symptoms that begin in early childhood and can continue into adulthood, causing difficulties at home, at school, at work, and within the community if not recognized and treated.
- **What are the symptoms of ADHD?**
  - **Inattention**. This is the most common symptom.
  - **Impulsiveness**.
  - **Hyperactivity**.
- **What causes ADHD?**
  - The exact cause is not clear. However, it is known that chemical balances in the brain affect temperament and behavior.

K. Attention Deficit Hyperactivity Disorder ADHD

What are the symptoms of ADHD?
Inattention. This is the most common symptom. In addition to having difficulty paying attention, people with this ADHD symptom often are unable to consistently focus, remember, and organize. They may be have a hard time starting and completing tasks that are boring, repetitive, or challenging. We tend to think the person is not paying attention to anything, when, in reality, they are paying attention to *everything* and have difficulty focusing on one particular thing*.*

Impulsiveness. People who frequently act before thinking may not make sound judgments or solve problems well. They may also have trouble developing and maintaining personal relationships. An adult may not keep the same job for long or spend money wisely.

Hyperactivity. A hyperactive child may squirm, fidget, and climb or run when it is not appropriate. These children often have difficulty playing with others. They may talk a great deal and not be able to sit still for even a short time. Teenagers and adults who are hyperactive don't usually have the more obvious physical behaviors seen in children. Rather, they often feel restless and fidgety, and are not able to enjoy reading or other quiet activities.

Symptoms vary by individual and range from mild to severe. Symptoms of ADHD can be similar to those of other conditions, such as: Learning disabilities; Oppositional Defiant Disorder (ODD); Conduct Disorder; Anxiety Disorder; Depression. These conditions are sometimes mistaken for ADHD. They may also occur along with ADHD, which can make diagnosis of the primary problem difficult.

What causes ADHD?
The exact cause is not clear. However, it is known that chemical balances in the brain affect temperament and behavior. The condition runs in families, although many adults do not recognize their own ADHD symptoms until their child is diagnosed with the condition. More research is needed to determine exactly how genetic factors influence ADHD.

Providing Support

- Support medication compliance
- Encourage good behavior
- Discourage inappropriate behavior
- Remain calm
- Follow a routine
- Provide frequent breaks.

Although there is no cure for ADHD, treatment can help control symptoms. Stimulant medications, such as amphetamine (Dexedrine or Adderall) and methylphenidate (Ritalin, Concerta, or Metadate CD), are the most effective treatment for controlling symptoms in children. Antidepressant medications may help control ADHD symptoms if stimulant medications are not effective.

You can help by encouraging good behavior – with words and rewards. Look for positive actions to praise – even when it is a behavior most people take for granted.
Discourage inappropriate behavior – consistently and clearly. Encourage voluntary time out, take time out for a few minutes in a quiet place. Be consistent in what you expect. Remain calm in what you say and do. Follow a daily routine. For some people, it may be helpful to offer fewer choices, offering only two choices instead of 10. Provide frequent breaks.

In addition to medication, some people may benefit from socialization training and behavior management, especially if they also have other emotional or mental health conditions along with ADHD. Specific medications or behavioral techniques may vary, depending on whether ADHD is the primary or secondary problem.

Alzheimer's

- **What is Alzheimer's disease?**
  - A progressive condition that damages areas of the brain involved in memory, intelligence, judgment, language, and behavior.

- **What causes Alzheimer's disease?**
  - The causes of Alzheimer's disease are not fully known.

- **What are the symptoms of Alzheimer's disease?**
  - Memory loss.
  - Inability to use judgment and make decisions.
  - Confusion about what time and day it is.
  - Getting lost in familiar places.
  - Difficulty learning and remembering new information.
  - Difficulty expressing themselves
  - Decreasing ability to perform everyday tasks

L. Alzheimer's

Alzheimer's disease is a progressive condition that damages areas of the brain involved in memory, intelligence, judgment, language, and behavior. It is the most common form of mental decline, or dementia, in older adults. Alzheimer's disease is more severe than the mild memory loss that many people experience as they grow older. It affects not only memory but also behavior, personality, ability to think, and the ability to function from day to day. Close family members usually notice symptoms first, although the person affected also may realize that something is wrong.

What causes Alzheimer's disease?
The causes of Alzheimer's disease are not fully known. Most experts believe there is probably more than one cause. Studies of inherited and environmental factors are beginning to provide some answers.

What are the symptoms of Alzheimer's disease?
Typical early symptoms of Alzheimer's disease include:
Memory loss; Inability to use judgment and make decisions; Confusion about what time and day it is; Getting lost in familiar places; Difficulty learning and remembering new information; Difficulty expressing himself or herself; Decreasing ability to perform everyday tasks like cooking a meal or paying bills, etc.

As the disease progresses, these symptoms get worse. The person may also develop strange new behaviors and withdraw from family and friends. Hallucinations, delusions, and paranoia are common; some people may become verbally or physically aggressive or abusive. Eventually the person may forget how to perform basic tasks like eating, dressing, bathing, using the toilet, or getting up from a bed or chair and walking.

Providing Support

- **Improving memory and daily functioning.**
  - ☐ Encourage medication compliance.
- **Dealing with new and unusual behaviors.**
  - ☐ Ensure that the person is in a safe, healthy environment, providing basic care and assistance with eating, dressing, bathing, using the bathroom, and other daily activities, and dealing with behavior problems.
- **Treating other conditions.**
  - ☐ Depression is common in people who have Alzheimer's disease, especially in those who are aware that they are losing their memory and ability to function on their own. Treatment with medication often can improve depression and help the person cope with the disease.

Improving memory and daily functioning. Several prescription medications may temporarily improve memory and thinking problems that occur with Alzheimer's. The improvement varies from person to person and may not last, but they are effective for some people.

Dealing with new and unusual behaviors. Most of the treatment for Alzheimer's disease happens at home and is provided by the person's family or other caregivers. It consists of ensuring that the person is in a safe, healthy environment, providing basic care and assistance with eating, dressing, bathing, using the bathroom, and other daily activities, and dealing with behavior problems. The behaviors that people with Alzheimer's sometimes develop can be frustrating to deal with and hard to understand. Medications sometimes may be used to treat behavior problems when other approaches to the problem have not worked, but nondrug approaches are preferred when possible.

Treating other conditions. People with Alzheimer's disease may have other medical problems that can make symptoms worse. For instance, depression is common in people who have Alzheimer's disease, especially in those who are aware that they are losing their memory and ability to function on their own. Treatment with medication often can improve depression and help the person cope with the disease. Hearing and vision problems can add to the person's confusion and agitation; these problems are often easy to correct.

Principles of Caregiving
Developmental Disabilities

SECTION III — DEVELOPMENTAL STAGES

Introduction

- No two people are alike

- Development is a step-by-step process
- Individual development in physical, cognitive and social/emotional areas does not proceed evenly

Individuals with disabilities are infants, children, adolescents, young adults and elderly who have a life to live in the same respect as everyone else. Today, public concern and attention is directed toward providing the opportunities for life, liberty and the pursuit of happiness to all citizens. Direct support professionals will be joining a large and distinguished group of parents, teachers, physicians, therapists, professionals and friends who are working to help individuals with disabilities live their lives in a way as close to "normal" as possible.

The old cliché that says "No two people are alike" is certainly true of people with special needs. It is important for direct support professionals to remember that no two individuals with a disability are alike and that people with the same disability may learn to live with it in different ways.

Development is a step-by-step process. For example, learning to walk may involve as many as fifteen components, beginning with pulling to a standing position and ending with walking without holding on. Most children progress through each step rather than skipping from step 1 to step 15. Because of these sequential patterns, determining a child's or youth's level of development is important so the child or youth can be assisted to reach the next step.

Individual development in physical, cognitive and social/emotional areas does not necessarily proceed evenly. One child (or adult) may be at a different developmental stage for each area. It is likely, however, that the person who has accelerated in one area will be advanced in other areas as well. Also, the person who is delayed in one area often is delayed in other areas as well. An obvious exception is a person who has a physical disability who might, therefore, be delayed in acquiring physical skills but is not delayed in other areas.

Please remember, when referring to developmental stages, we are talking about the development of a child without a developmental disability. The ages on the following slides refer to developmental stages people go through. The ages are provided as reference points. Please note, people develop at all different paces but typically follow the same sequences.

Developmental Domains

- Physical development
- Social development
- Emotional development
- Cognitive development
- Self Help
- Speech/Language

A. Developmental domains

Physical development – is the gradual gaining of control of large and small muscles. It includes acquiring large muscle skills such as sitting, crawling, walking, running, and throwing. Developing small muscle skills such as holding, pinching and flexing fingers and toes.
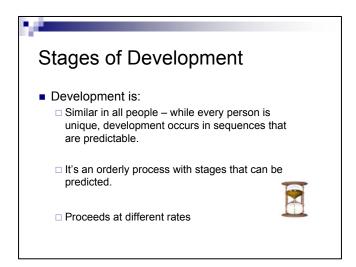
Social development – is the process of getting to know and value the other people in their lives. It involves being able to establish and maintain relationships, develop social skills, and gets along with others. It includes learning to share, cooperate, takes turns, and negotiate with others.

Emotional development – refers to the feelings people have about themselves, other people in their lives and the environment in which they live.

Cognitive development – is the process of learning to think and to reason

Self help – is the development of daily living skills such as toileting, self feeding, dressing and so forth.

Speech/Language development – the process of learning to communicate with others through verbal or other communication means

Stages of Development

- Development is:
  - □ Similar in all people – while every person is unique, development occurs in sequences that are predictable.
  - □ It's an orderly process with stages that can be predicted.
  - □ Proceeds at different rates
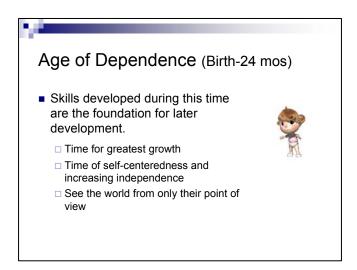
B. Stages of Development

The stages of development will follow patterns that are based on basic principles typical of all people, whether they have disabilities or not. These principles state that development is:

Similar in all people. While every person is unique, development occurs in sequences that are predictable.

An orderly process with stages (patterns) that can be predicted. Knowing the predictable sequences of behavior helps in recognizing typical (normal), delayed or accelerated patterns of behavioral change and growth and enables parents, educators, and other professionals to develop individualized programs.

Proceeds at different rates from the general to the specific, from the upper portions of the body toward the lower portions -from head to toe, and from the center of the body to the outer body parts.

Age of Dependence (Birth-24 mos)

- Skills developed during this time are the foundation for later development.
  - Time for greatest growth
  - Time of self-centeredness and increasing independence
  - See the world from only their point of view

C. Age of Dependence
The skills developed during this time are the foundation for all later development. This is the stage of greatest growth in children. They go from being dependent on parents for food, movement, and stimulation to being able to control these things themselves. By the end of this age, they can walk and climb alone; tell caregivers what they want for food themselves; and entertain themselves for short periods of time. This is a time of self-centeredness and increasing independence. Children of this age are not selfish, rather they can only see the world from their own view point. The world is what they can do to it. The world is action and making things happen.
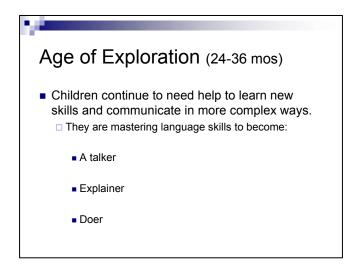
Interactions
Fine motor (e.g., using the small muscles to grip a toy), gross motor (using the large muscle groups to run or throw), communication, cognitive (thinking and understanding skills), and social skills.

Communication
Included are skills that are needed for talking and also for signing or using a picture communication system for those with speech and language difficulties. Other skills involved in the area of communication are cognitive, interaction and motor areas of development.

Self-help
Skills necessary for children to feed, dress and bathe themselves. They are the skills that decrease a child's dependence on parents and caregivers and decrease the amount of time required for physical care giving.

Age of Exploration (24-36 mos)

- Children continue to need help to learn new skills and communicate in more complex ways.
  - They are mastering language skills to become:
    - A talker
    - Explainer
    - Doer

D. Age of Exploration

Children continue to need help from their family, neighbors, and environment to learn how to use these new skills to interact and communicate in more complex ways. The child has mastered many more skills and language, so that they become a talker and will begin jumping off the furniture or riding a bike. Children will spend more time in active play at the beginning of this age.

Social and Emotional

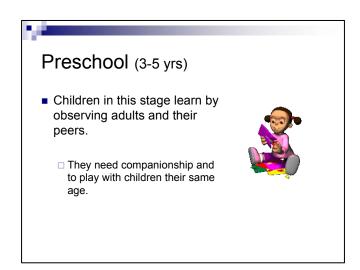The skills in this area include those involved in talking, signing, and/or using a picture communication system for those individuals with speech difficulties, and understanding what is meant when adults and peers talk with the child. During the two to three year age range, children may not be learning a lot of new words, but they are putting together the words they know and making longer and more complicated sentences. Sentences are longer and more complicated from the perspective of what they say, and children understand longer and more complicated sentences that are said to them.

Cognitive

Skills in this area include feeding, dressing, toileting, and bathing. These routines include component skills of gross motor, fine motor, communication, cognition, and interaction. Two to three year-old children are learning how to use these skills to finish each routine, but sometimes they want to play during these routines. They want continue at their own pace and they want to make the choice of when, and how, to do each routine. Many times, they use their skills during these routines to be independent from what others around them want them to do. They want to experiment and try combinations of new skills.

Preschool (3-5 yrs)

- Children in this stage learn by observing adults and their peers.
  - They need companionship and to play with children their same age.

E. Preschool

Children in this stage learn by observing adults and their peers. While they are self-centered, children between the ages of three and five also need companionship and need to be able to play with children the same age.

Physical
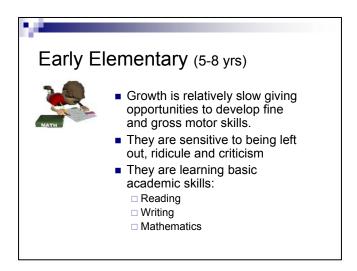
During this period of time the rate of physical growth begins to slow down. Children begin to play with toys that can be manipulated. For example: they enjoy playing with clay, driving nails and pegs, and building towers using small blocks. They can walk on a line, hop on one foot, and ride and steer a tricycle.

Social and Emotional

They always seem to be on the go, exploring and learning about their world. At the same time they are also forming strong attachments with caregivers and require a great deal of attention and support from adults. Their attention spans are short and they can be easily diverted.

Cognitive

They begin to learn to take turns and share, and they move from parallel play (e.g., three children playing with blocks but not interacting with one another) to cooperative play (three children working together to build a tower with the blocks). They are interested in talking to new people and visiting new places. They begin to expand skills through the increasing use of imaginative play and the use of other methods for satisfying their curiosity.

Early Elementary (5-8 yrs)

- Growth is relatively slow giving opportunities to develop fine and gross motor skills.
- They are sensitive to being left out, ridicule and criticism
- They are learning basic academic skills:
  - Reading
  - Writing
  - Mathematics

F. Early Elementary

The rate of growth continues to be relatively slow, providing children with an opportunity to develop greater coordination in both gross and fine motor areas. While children are learning to get along well with their peers, they are also sensitive to being left out, ridicule, and criticism. In school, children ages five to eight are learning basic academic skills -reading, writing and mathematics.

Physical
They learn to skip, skate, ride two-wheel bikes, walk balance beams, grasp a pencil in an adult manner, move beyond cutting straight lines to cutting out simple shapes and the use of the predominant hand for writing and throwing is established.

Social and Emotional
Developing rules, following and playing by the rules becomes very important. They begin to understand the values of their cultural environment. They like to try out the skills they are learning in many settings. The children in this age group identify strongly with their teachers and other adults. Encouragement, recognition, praise and adult support are very important. They also need time to adjust to new experiences and situations.

Cognitive
They are interested in learning how and why things move or work. Their attention spans remain short. They need time to practice what they are learning.

Pre-adolescence (8-11 yrs)

- Children in this age range are enthusiastic about almost everything.
- They enjoy:

  - Talking

  - Expressing abstract ideas

G. Late Childhood/Pre-Adolescence
This is an overlapping period because it includes the closing years of childhood and the beginning years of adolescence. Children in this age range are enthusiastic about almost everything. At this stage of their development, children enjoy talking, and expressing abstract ideas.

Physical
It is marked by slow and steady growth. Both girls and boys need opportunities to improve the coordination of their large and small muscles and they require plenty of sleep and well-balanced meals.

Social and Emotional
They are imaginative and like to explore. Peer group approval becomes increasingly important. They are interested in organized games and competitive activities. They are frequently socially insecure; and they value secure, supportive relationships with adults.

Cognitive
They like to experiment and solve problems and are eager to acquire new skills. Language usage is influenced by peers and they are oriented to shared interest among peers.

Adolescence (*12 yrs – Adult)*

- Period of change that signifies the transition from childhood to adulthood.

- Characterized by rapid growth and marked changes in body proportions.

- Cognitively, adolescents are able to shift from concrete to abstract thinking.

H. Adolescence

This is the period of change in a person's life that signifies transition from childhood to adulthood. It is characterized by rapid growth and marked changes in body proportions. There is a definite relationship between physical development and the ways adolescents perceive themselves. Cognitively, adolescents are able to shift from concrete to abstract thinking.

Physical

Changes may begin and end any time between the ages of 6 and 19. Primary sex characteristics develop, and in girls reproductive organs mature. Secondary sex characteristics including marked changes in the voice, breast development in girls development of underarm, facial and pubic hair begins in early adolescence; chest hair' does not appear until late adolescence. Rapid growth and body changes are likely to be accompanied by periods of fatigue. Acne may develop, and both girls and boys may experience periodic headaches and backaches.

Social and Emotional

It is not uncommon for many adolescents to experience feelings of self-consciousness, shyness and insecurity because of the sexual changes taking place. Adolescent emotions are often intense, uncontrolled and seemingly irrational. Throughout adolescence, emotional maturity grows as individuals develop more self-control over their emotional responses. During this period the peer group influences young people more than any other factor. They are still dependent on their family but try to achieve independence and autonomy. As the dependence on home lessens, security is found among friends who share the same values and attitudes.

Cognitive

They develop the ability to test tentative hypotheses against available evidence. Moral development matures during adolescence, young people begin to define their own moral principles rather than accepting those of their parents without question. Adolescents begin to develop specific skills and talents and start to set goals for themselves.

Principles of Caregiving
Developmental Disabilities

SECTION IV — HEALTH AND MEDICAL

Health and Medical Care

- Instructions on the detection of signs and symptoms of injury, illness, and change in health status, including infectious diseases.

A. Observation

The best way to determine if an individual is not feeling well is to observe them. Pay close attention to the individuals you work with.

Signs & Symptoms:

General Appearance— "He doesn't look right"
Facial Expression— Drawn, haggard, anxious, dull, listless
Eyes— Heavy, unusually bright, inflamed, bloodshot, not able to see clearly
Nose— Runny nose, sneezing, coughing, difficulty breathing
Mouth & Throat— Bleeding gums, tongue dry, tongue coated with yellow or white
Voice— Weak, hoarse, groaning, moaning
Earache— Pulling at ears, pain
Skin— Change in color, rash, unhealed sores, itching, excessive perspiration
Edema— Swelling, usually in fingers or feet & ankles
Weight— Loss or gain
Appetite & Hunger— Change from the usual—might reject favorite foods
General Malaise— Vague discomfort, weakness, unusually tired
Irritability— Unwillingness to play or work, refusal of food, grouchy
Fever— Elevated or lower than normal
Respiration & Pulse— Different rhythm or rate, shallow breathing, short of breath
Pain— Sharp or dull, constant or intermittent, local
Nausea— Vomiting or gagging feeling
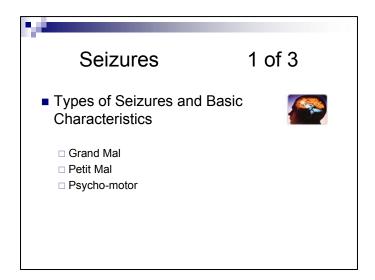**Diarrhea & Constipation**— Note color, consistency of stool, any blood, etc.
Urination— Inability to or frequent urination, painful urination, blood in urine
Rash, Boils & Sores— On any part of body
Convulsions— Increase in number, severity, duration
Movement— Change in ability to roll over, sit, walk or use limbs
Hemorrhage— Bleeding from skin, mouth, nose, etc.

Seizures   1 of 3

- Types of Seizures and Basic Characteristics

  ☐ Grand Mal
  ☐ Petit Mal
  ☐ Psycho-motor

B. Seizures

Epilepsy is characterized by uncommon discharges of energy from brain cells leading to various sets of symptoms. It is not a disease with a single cause; for 70% of people with epilepsy, the cause is unknown. For the remaining 30%, the most common causes are head trauma, brain tumor, stroke, lead poisoning, infection of brain tissue, heredity, and prenatal disturbance of brain development. Every person with epilepsy is unique in symptoms, frequency, duration and types of seizures experienced.

1. Types

Seizure types can be broken into:

Partial Simple: Consciousness is maintained

Partial Complex: Consciousness is lost or impaired

Partial seizures are the most common seizures.

A person having a partial seizure may carry on activities without being fully conscious although he or she may appear to be. Often, the activities are normal but done in the wrong places. For example, a person might clap his or her hands repetitively while working. Sometimes, a person may appear to be hallucinating.

Generalized Absence (pronounced "ab-sonce"): Altered awareness

Generally lasts under 30 seconds. They usually cause a brief loss of consciousness. The person appears to have a lapse of attention or a moment of day dreaming. Sometimes a person's face may twitch or head may drop. Falling down does not usually occur. The person likely will not remember the seizure.

Generalized Convulsive: Characterized by muscle contractions with or without loss of consciousness (often includes what is known as "grand mal" seizures)

2. Basic Characteristics

Seizures affect each person differently. Some phases may include:
1. Aura: The person may feel cold or smell something bad. These sensations are often a signal prior to the onset of the seizure.
2. Tonic Phase: A generalized contraction of the whole body will likely cause the person to cry out and/or then fall. He or she does not feel pain at this time. The jaw clamps shut and salivation increases and collects in the mouth and throat.

Breathing may be interrupted and the person may turn blue. This phase usually lasts 20 to 30 seconds.

3. Colonic phase: In this phase, the muscles of the body alternate with contractions and relaxations. This causes the body to twitch and jerk. The person may lose control of his or her bowel or bladder.

4. Recovery Phase: The muscles relax. At first, the person is not easily aroused and may seem confused. Gradually the person returns to an alert state.

Explain—*If a person appears to be choking, do not perform the Heimlich maneuver. The object the person may be choking on will usually discharge during the seizure.*

- Factors that Contribute to Seizure Activity

- Appropriate Response to Seizure Activity

- Common Treatments Utilized to Control Seizures

3. Factors

There are certain factors that can contribute to a seizure including: missed medication (#1 reason), stress, anxiety, hormonal changes, lack of sleep, photosensitivity, dehydration, drug/alcohol use, drug interactions (particularly with over the counter medications), strobe-like movements and light.
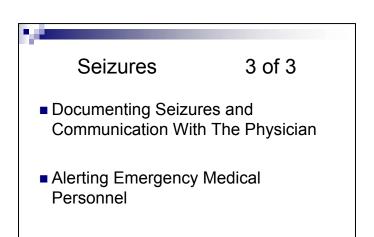
4. Appropriate response

Observing a seizure can be alarming. If a person has a seizure, the main rule is to **keep calm**. Remember that there is nothing you can do to stop a seizure once it has started, but there are things you can do to help:

1. Protect the person from getting hurt. Do not try to hold the person down, but clear the immediate area.
2. Do not interfere or stop the seizure. Do not try to open the mouth or put anything inside the mouth. A person is unlikely to swallow his or her tongue.
3. Once the seizure is over, turn the head to the side. If you can turn the head without too much strain, it will allow saliva to drain out of the mouth. Only do this if you can do it gently.
4. Provide support after the seizure. After a seizure, a person may be tired and may need to rest. While recovering from a seizure, a person may have difficulty eating or drinking, so it is best not to provide food or drink until he or she is fully recovered. Reassurance, a quiet word, respect, comfort and a chance to sleep are often the best things to provide.

5. Common treatments

    Anti-convulsants are medications used to control seizures. Eighty-five percent of all seizures can be controlled with these medications. It is often necessary for a person with seizures to take anti-convulsants for his or her entire life. Based on the type of seizure, a doctor may have blood drawn occasionally, but usually every three months. Some commonly used anti-convulsants are: Dilantin; Clonopin; Zarontin; Phenobarbitol; Mebaral; Tegretol.

        Other treatment may include surgery or options other than medication, such as a specialized diet or lifestyle modifications.

- Documenting Seizures and Communication With The Physician

- Alerting Emergency Medical Personnel

6. Documenting seizures

Observing a person during a seizure is important. Reporting them can help in treating the seizures. Your employer may ask that you document seizure activity on a form similar to this one.

7. Alerting emergency medical personnel

There are some situations that call for swift medical attention. Call the doctor or an ambulance immediately if a seizure lasts for more than five minutes longer than their typical seizure. (For example, if someone regularly has 2 minute seizures, you would wait until the seizure has lasted 7 minutes before calling 911.) **EXCEPTION:** *If a person is having a convulsive generalized seizure ("grand mal"), call immediately if the person is not known to have seizures or lasts more than 5 minutes.*

Refer to a person's seizure chart or records, or your agency's policies for additional emergency information. Anyone working with people who experience seizures should be required to wear a watch with a second hand.

A doctor or ambulance should also be called immediately if a person has a series of seizures that are not typical for that individual, or if the person has continued difficulty breathing.

G - Tubes

- G-Tube is a Gastrostomy Tube
  - Used to assist people who have difficulty eating by mouth, or difficulty taking medications.

  - A tube that feeds directly into the stomach.

C. Feeding Tubes

A G-tube is a Gastrostomy tube or a tube that is surgically inserted into the stomach through the stomach wall. G-tubes are used to assist people who have difficulty eating by mouth or difficulty taking medications.

A G-tube stays in place until changed by the physician or other nursing personnel. If you are working with a person who has a g-tube and the tube comes out or is pulled out, you will need to contact the family or medical personnel. You will also receive additional training specific to that person and their G-tube.

Principles of Caregiving
Developmental Disabilities

SECTION V — MEDICATION ADMINISTRATION

Introduction

- Administering medication is a tremendous responsibility
- What is a "drug"?
  - Prevent Disease
  - Aid in the Diagnosing of a Disease
  - Treat a Disease
  - Restore Normal Functioning of Body Cells
  - Maintain Normal Functioning of Body Cells

Not all services allow for the administration of medication, some will have the family or medical professionals do this. Pass out medication training packet, medication log, and test. Explain that there is a test and it's important to pay attention. Have all paperwork, pillbook, and sample medication box out and available.

A. Introduction

Administering medication is a tremendous responsibility. There are thousands of medications on the market and many new ones are approved for release each year. You are expected to know the nature of every drug you give. To administer medications properly, it is essential that you understand the meaning of the terms which will be used in this medication training—you will encounter and use these terms on a daily basis.

The dictionary defines the term "drug" as a "substance or mixture (other than food)" that is used to do one or more of the following:
1. Prevent Disease - e.g., Hepatitis B Vaccine
2. Aid in the Diagnosing of a Disease - e.g., Barium for X-ray studies
3. Treat a Disease - e.g., Penicillin to fight infection
4. Restore Normal Functioning of Body Cells - e.g., Calcium
5. Maintain Normal Functioning of Body Cells - e.g., Vitamins

General Info

- Drugs are very useful, but they can also prove to be very dangerous
- There is no such thing as a harmless medication
- Anytime you take medication, you are open to risks such as:
  - Side effects
  - Tolerance
  - Hypersensitivity

B. General Information

Drugs are very useful, but they can also prove to be very dangerous. The physician, or physician's assistant, or nurse practitioner with a physician, knows the actions of each prescribed drug, and is the only person qualified to prescribe how they should be used. There is no such thing as a harmless medication.

Anytime you take medication, you are open to risks such as:

Unpleasant or dangerous side effects can result from administering any medication. Too high a dosage may produce toxic effects or worse yet, irreparable damage, such as liver damage.

Another frequently observed effect of drug administration is that of an increased amount of the drug being required to produce the same effect than a lesser amount previously produced. This phenomenon is known as tolerance.

Hypersensitivity to a drug is an allergic response or reaction. For example, an allergic reaction to penicillin may range in severity from a simple rash to anaphylactic shock.

Medication Routes

- **Routes of administration:**

  1. Oral (in the mouth)
  2. Rectal (inserted in rectum)
  3. Sublingual (under the tongue)
  4. Topical (lotion or powder)
  5. Optic (on the eye)
  6. Otic (in the ear)
  7. G-Tube or NG Tube (a tube to the digestive system)
  8. Inhalation (in the nose)

  Note ~ In the behavioral health field LPN's and RN's may administer intravenous (in the vein) or intramuscular (in the muscle) medications.

C. Medication Routes

Most of our medications will be administered orally or topically.

* (G-tube—gastric tube; NG-tube—nasal gastric tube)

Forms of Medications

- Some forms of medications we will be dealing with are:
  - Liquid preparations
  - Tablets
    - Scored
    - Capsules
  - Ointments/Creams
  - Suppositories

D. Forms of Medications

Liquid preparations are those containing a medication, which has been dissolved, or suspended in a solvent -- two common solvents are water and alcohol. Liquid preparations are designed to be taken internally are quickly absorbed through the stomach or intestinal walls. If you have a client who has a problem with alcohol please remind the physician when they are prescribing liquid medications.

Tablets are the most popular form of medication used today.

Scored: scored tablets are marked with indented lines which divide them into halves or quarters. This scoring allows them to be broken easily for administering a proper dose (for example, Lasix).

Capsules two part containers made from gelatin.

Ointments/Creams, which are generally used on the skin as a topical medication.

Suppositories are mixtures of drugs in a waxy base, which melts at body temperature. They are molded into shapes that are suitable for insertion into the rectum, vagina and urethra. An example is a Dulcolax suppository.

Terms & Abbreviations

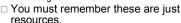|	
■ BID	Twice a Day
■ D/C	Discontinue
■ HS	Hour of sleep
■ OTC	Over the counter
■ PM	Afternoon
■ PO	By mouth
■ NPO	Nothing by mouth
■ PRN	As needed
■ QD	Every day
■ QHS	Every hour of sleep
■ TID	Three times a day
■ Q.I.D.	Four times a day

E. Terms and Abbreviations

Common Abbreviations: With medications the physician will use many abbreviations, here are some of the most common:

It is important for Direct Support Professionals to understand these terms and abbreviations when deciphering a doctor's order on a prescription, evaluation form, or a standing order.

Medication Resource

- Whenever giving medications it is a good idea to have a medication resource (i.e. "pill book", Physicians Desk Reference, printout from pharmacy) on hand.

  □ In a pill book you should find the following information about medications:
    - Indications
    - Adverse Reactions
    - Side Effects
    - Warnings
    - Dosages
  □ You must remember these are just resources.

F. Medication Resource

Whenever giving medications it is a good idea to have a medication resource (i.e. "pill book", Physicians Desk Reference, a printout from the pharmacy) on hand, in some fields this may be a requirement. Direct Support Professionals should be familiar with the medication resource, its location and its use. If you have questions about a medication, LOOK IT UP.

In the medication resource you should find the following information about medications:

INDICATIONS - this refers to various conditions, which can be present in the client for whom a physician has prescribed a drug. Remember, very few clients have all the medical problems listed for the use of a drug.

ADVERSE REACTIONS - this refers to predisposing conditions, which would make giving the drug dangerous or harmful.

SIDE EFFECTS – describes the common and uncommon reactions that people may experience from this medication. We should be familiar with the side effects associated with the medication being administered.

WARNINGS - this may be thought of as "precautions" . . . those "red light" conditions, which alert the physician to possible complications, interactions or situations, which may need further attention.

DOSAGES - this section is added to gain familiarity with the quantity of drug administered.

You must remember that these books are only resources. Many of the indications, contraindications, warning and dosages have been compiled using "normal, healthy" adults. Many people have unique medical problems, and some of the above information may not apply. It is important that you be aware of any unique medical problems and always ask questions before administering medications.

Medication Storage

- Rules regarding medication storage will differ between fields, however the following guidelines are a good ideas.
  - Under sanitary conditions
  - In their original container
  - Clean and closed tightly
  - Consistent with the label instructions. (i.e. in the refrigerator, out of direct sunlight, below 80 degrees)
  - In locked storage
  - Inventoried regularly
  - Disposed of when discontinued

G. Medication Storage

Rules regarding medication storage will differ between fields, however the following guidelines are a good ideas.

Medications must be stored under sanitary conditions. All medications are to be stored in their original container and the container must be kept clean. Containers for liquid medications should be wiped clean and closed tightly following administration.

Medications must be stored in a manner consistent with the label instructions. (i.e. in the refrigerator, out of direct sunlight, below 80 degrees)

In residential group homes, medications are required to be locked, unless specific exceptions have been made and approved in writing. This includes medication in refrigerators.

Medications should be inventoried regularly to ensure they are not expired. If medications have expired, they should be disposed of properly. This includes over the counter medications.

Labels and Packaging

Rules regarding labels and packaging will differ between fields, however the following guidelines are a good ideas.

- Each medication that is prescribed must be labeled with the person's name and the current dosage
- New labels should be obtained for medication containers having soiled, damaged, incomplete, illegible or make-shift labels
- Making a change to a label
- Taking medications out in the community
- Checking medication

H. Labels and Packaging

Rules regarding labels and packaging will differ between fields, however the following guidelines are a good ideas;

Each medication that is prescribed must be labeled with the client's name and current dosage. An over the counter medication which is prescribed on a regular or ongoing basis for a client does not require a prescription label but the package label should be intact and should be labeled with the client's name and dosage.

New labels should be obtained for medication containers having soiled, damaged, incomplete, illegible or makeshift labels.

When a medication order is changed Direct Support Professionals can make a change to the label if they have a physician's order, which verifies the new order. The change should be made by drawing a single line through the change and writing the correct information on the label. Direct Support Professionals should try to get a new prescription label as soon as possible.

If a person needs to take medications out in the community (i.e. to day program, work, Direct Support Professionals should try to obtain a separate prescription for that medication. If that is not possible, the medication should be placed in a container, which is labeled with the person's name, name of the medication and the dosage.

Always remember to check the contents of each medication container with the label. Just because the label on the container says the medication is Dilantin, don't take it for granted. It is our responsibility to make sure we know the appearance of all drugs that we administer. If in doubt, refer to the picture section of the Pill Book or contact the pharmacy. Do not just give because the label says so.
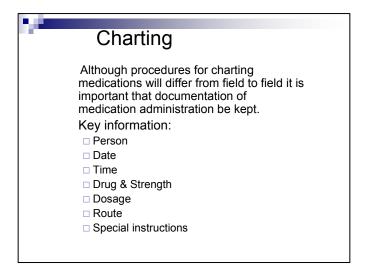
Types of Medications

- There are many different classifications of medications.
  - Anti-Convulsants
  - Antibiotics
  - Anti-Inflammatory
  - Anti-anxiety
  - Anti-Psychotic
  - Beta Blocker
  - Anti Depressants

I. Types of Medications

There are many different types of medications, here are some of the most common:

♦ Anti-Convulsants are medications used to treat individuals with seizure disorders: Carbamazepine/Tegretol, Dilantin, Depakote, Klonopin/Clonazepam, Lamictal, and Phenobarbital

♦ Antibiotics are medications used to treat bacterial and other infections: Amoxicillin, Cephalexin, Penicillin, Tetracycline

♦ Anti-Inflammatory medications are used to treat arthritis, bursitis and gout: Anaprox, Naprosyn

♦ Anti-anxiety medications are for symptoms of anxiety, tension and agitation: Ativan/Lorazepam, Buspar

♦ Anti-Psychotic medications are used for psychotic disorders, control of agitation or aggressiveness: Chlorpromazine/ Thorazine, Prolixin, Serentil, Mellaril/Thioridazine, Stelazine/Trifluoperazine, Haldol/Haloperidol, Lithium, Risperdal

♦ Beta Blockers are used to treat high blood pressure: Inderal/Propranolol, Lopressor, Procardia

♦ Anti-Depressants are used to treat moderate to severe depression: Paxil, Prozac, Effexor, Amitriptyline, and Elavil.

Charting

Although procedures for charting medications will differ from field to field it is important that documentation of medication administration be kept.

Key information:
□ Person
□ Date
□ Time
□ Drug & Strength
□ Dosage
□ Route
□ Special instructions

J. Charting

Although procedures for charting medications will differ from field to field it is important that some sort of documentation of medication administration be kept.

When documenting medication administration here is some key information to consider:

Person receiving the medication.

Date the medication was given.

Time: the hour a medication is to be administered (8:00am, 12:00 noon etc.).

Drug & Strength: the name of the medication as it appears on the prescription label and the medication dosage (milligrams).

Dosage: how the medication is to be given (i.e. take two tablets twice daily)
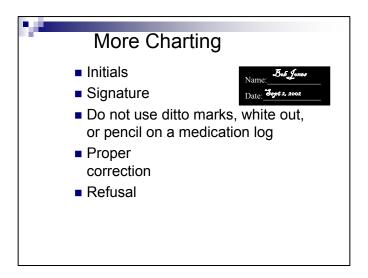
Route: the route of administration (i.e. oral, topical, sublingual etc.)

Special Instructions: if the physician has indicated take with meals or on an empty stomach, it should be documented under method of administration.

On the back of the medication log we should document:
♦ Medication name: as it appears on the prescription label.
♦ Count: First and Last count of the month
♦ Rx#: the number on the current bottle

Activity—*Have each student complete medication log for sample bottle in medication box.*

More Charting

- Initials
- Signature
- Do not use ditto marks, white out, or pencil on a medication log
- Proper correction
- Refusal

Name: *Bob Jones*
Date: *Sept 2, 2002*

K. Medication Log

Keep in mind that the medication log is a legal document. Once the information regarding the medication and how it is to be administered is documented on the log and upon visual confirmation the medication was received by the client you should initial across from the medication time/dosage under the correct day.
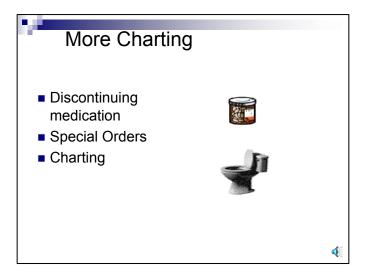
Somewhere on the medication log your name, and full signature should documented to correspond with your initials.

You should not use ditto marks, white out, or pencil on a med log.

If you make an error in any entry on the medication log proper correction procedure when addressing the error. It is typical to draw a single line through the error and circle the entry and write an explanation on the back. Do not use white out, do not black out the error, do not write over the error, do not erase.

If the individual refused the medication this should be documented using the appropriate procedure for your company.

Activity—Have students put name and initials on back of log.

More Charting

- Discontinuing medication
- Special Orders
- Charting

When a medication is discontinued proper disposal and documentation must occur. Garbage disposal or flushing down the toilet are two common means for disposal. A witness should be present when disposing of discontinued medication.

Document if a medication cannot be administered due to a special order.

Charting is an important part of medication administration.

Self Medication

- Independence
- Team approval
- If Direct Support Professionals are responsible for pouring or administrating, a log must be maintained

L. Self Medication

Many people can administer their own medications, or need minimal supports. Self-medication should be encouraged, advocated for, and work towards, to increase the person's independence.

The team should be taking into consideration the individual's skills/abilities and any medical or behavioral issues prior to approval. Once the individual with their team has approved self medication they need to determine what medications this self administration pertains to and what role Direct Support Professionals are to play (if any).

- The role of the staff will vary from field to field, however, the general rule is if Direct Support Professionals are responsible for pouring and/or administering medications a log must be kept. If the individual is totally independent it is up to the team as to what type of documentation will be maintained

Administration

- Medication administration procedures will vary from field to field and company to company, however these key components should be involved to reduce chance for error:
  - Procedure
    - Designate an area
    - Inform your co-worker
    - Retrieve all necessary supplies
    - TRIPLE CHECK
    - Pour
    - Administer
    - Document

M. Medication Administration

Medication administration procedures will vary from field to field and company to company, however these key components should be involved to reduce chance for error:

1. Preparing the Area

Designate an area to administer medications. This should be an area that will have little chance for interruption. This area should be clean and sanitary. Wash your hands or wear gloves. Inform your co-worker and the individuals that you are about to administer medications. This will cue people not to distract you. Retrieve all necessary supplies and materials such as medication cups, measuring cups/spoons, water for the individuals to take their medications, the medication storage box, medication log, and a pen.

2. Correct Dosage

Take out the individual's medications, and medication log. Triple check to ensure it matches the medication recording log, medi-set, and bottle/bubble pack. You should be checking the "5 Rights" 1. Right Person, 2. Right Medication, 3. Right Time, 4. Right Dose, 5.Right Route.

3. Contamination

It is important to follow proper procedure to avoid contamination. Once you have ensured that you are administering the medication as prescribed, place the medication in the medication cup, careful not to touch it with your hands so you don't contaminate the medication . Ask the person to come to you if they refuse or are unable, be sure to lock the medication if you leave the immediate area. (Do not leave the medications unsupervised or unlocked). Hand the medication and the water or whatever is necessary to the person. Verify that they have taken the medication, don't let them hold the medication and walk away. You need to see the person take the medication.

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Determining an Error

- Every Direct Support Professional should review the medication log for blanks when administering medications. If a blank is found the staff person needs to determine if it is a medication error or a documentation/transcription error and follow the proper procedure.

N. Errors

1. Finding
Any of the following instances constitutes a medication error:

    1. <u>Wrong person</u> - giving an individual someone else's medication.

    2. <u>Improper dosage</u> - giving too high or too low.

    3. <u>Wrong time</u> - giving 4pm meds at 8pm.

    4. <u>Forgetting meds</u> - realizing at 4pm that 8am meds were not given.

    5. <u>Late</u> - giving meds more than one hour late.

Explain—*that errors happen. Direct Support Professionals are expected to be true to our values, honest and accountable.*

Finding Med Errors

- Try to verify if medication was given
- If medication was given correctly and documented incorrectly it is a transcription error and transcription error procedure should be followed.
- If any of the "Five Rights" did not occur it is a medication error and the medication error procedure should be followed. Procedures will differ from field to field many common components are:
  - Notify supervisor
  - Contact the medical personnel or follow standing order
  - Notify guardian if applicable
  - Fill out incident report

2. Medication

Try to verify if medication was given by doing a medication count, checking the bubble pack, and/or calling the Direct Support Professional that should have given the medication.

If medication was given and not documented correctly, or not at all, it is considered a transcription error and you should follow your employer's transcription error procedure.

When a medication error is found you should follow your employer's med error procedure. Procedures will differ from field to field, however, some common components are:
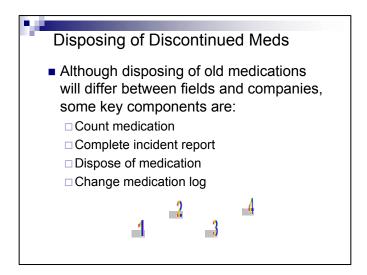
* Notify Supervisor or designee

* Contact the medical personnel- pharmacy, poison control, physician, nurse or follow standing order (We usually get better results from the pharmacy—doctors take too long to call back)

* Notify guardian if applicable

* Fill out an incident report

Finding Med Errors

- Key components for documenting a medication error:

  - ☐ Fill out an incident report
  - ☐ Describe the error
  - ☐ Contact medical personnel
  - ☐ Follow recommended action
  - ☐ Complete internal reporting procedure
  - ☐ Monitor the person involved in the error

3. Documentation

The procedure for documenting a med error will vary between fields and agencies, however these are some key components:

- Fill out an incident report including all pertinent information
- Make sure your incident report clearly describes the error
- Contact the appropriate medical personnel for instructions
- Follow the instruction of the medical professional
- Complete any internal paperwork necessary
- Closely monitor the client involved in the medication error

Disposing of Discontinued Meds

- Although disposing of old medications will differ between fields and companies, some key components are:
  - Count medication
  - Complete incident report
  - Dispose of medication
  - Change medication log

O. Disposal of Outdated Medications

When a medication needs to be disposed of you need to count or measure with a witness.

Using the incident report form document the name of the person, name of the medication being disposed, how the medication was disposed, why the medication was disposed, and the amount.

Have a witness watch you dispose of the medication (flush down toilet, garbage disposal, flush down sink). Make sure they go down, some meds float.

Both you and the witness sign the Incident Report.

Any time medication is disposed, follow charting procedure.

Principles of Caregiving
Developmental Disabilities

SECTION VI — SUPPORT PLANS

Plan Purpose

- Directs the provision services
- The plan must be in the best interest of the person served
- Binding legal document
- Roadmap for the individual's future

The best plan is person centered

A. Purpose

Directs the provision services – directs the provision of secure and dependable services in the areas that are necessary for the individual to achieve full social inclusion, independence and personal and economic well-being. The plan is to ensure that all team members are on the same page, working toward the same goals.

The plan must be in the best interest of the person served. The plan is not about available resources - it is about what the person needs. That is, the plan must be centered on the consumer's strengths, needs, and resources.

A support plan is a binding legal document – all team members must abide by and work to fulfill the directions of the plan.

It is a roadmap for the individual's future- the document should plot the course of the person's life for the next year or whatever term the plan is for.

Values to Use in Planning

- **EMPOWERMENT** of the individual and the family in the choices that they make through this process.
- Treat all members of the team with **MUTUAL RESPECT**, as we would wish to be treated.
- Demonstrate a **PASSION** and commitment to the individual and their wants and needs.
- Be **ACCOUNTABLE** to the team for the agreements and assignments.
- Build a relationship of **TRUST** .
- Be **HONEST** when providing information to the team.
- We have to have a **YES WE CAN ATTITUDE**

B. Values in Planning

If we look at and follow these values during the planning process, the plan will be centered on the consumer and will be in their best interest.

We believe in EMPOWERMENT of the consumer and the family in the choices that they make through this process.

We should treat all members of the team with MUTUAL RESPECT, as we would wish to be treated.
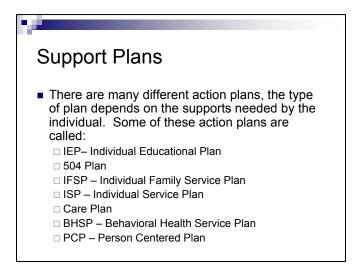
We should demonstrate a PASSION and commitment to the consumer and their wants and needs.

We need to be ACCOUNTABLE to the team for the agreements and assignments noted within the support plan document.

We have to build a relationship of TRUST with the consumer, the team and family members.

We must be HONEST when providing information to the team.

We have to have a YES WE CAN ATTITUDE, through out the planning process. We need to show our support and put all of our effort into supporting the people we serve achieve their goals.

Support Plans

- There are many different action plans, the type of plan depends on the supports needed by the individual. Some of these action plans are called:
  - IEP– Individual Educational Plan
  - 504 Plan
  - IFSP – Individual Family Service Plan
  - ISP – Individual Service Plan
  - Care Plan
  - BHSP – Behavioral Health Service Plan
  - PCP – Person Centered Plan

C. Types

There are many different support plans, the type of plan depends on the supports needed by the individual. Some of these support plans are called:

IEP – Individual Educational Plan – (used in the school system)

504 Plan – (used in schools for children with special health needs)

IFSP – Individual Family Service Plan (used for children 0-3 years of age with developmental disabilities)

ISP – Individual Service Plan (used for school aged children & adults with developmental disabilities)

Care Plan – (used in nursing homes and elderly care)

BHSP – Behavioral Health Service Plan (used for individuals with behavioral health needs)

PCP – Person Centered Plans (used for in-depth planning for individuals with disabilities)

Behavior Plan – (used to create a positive plan to address behavioral issues)

As a DSP for people with Developmental Disabilities you will primarily be working with a Individual Support Plan.

Team Membership

■ Who may attend:
  □ The individual
  □ The parent/guardian
  □ Case Manager/Support Coordinator
  □ Direct Support Professionals
  □ Friends, Family, Advocates, Neighbors and others as invited

teams meet twice yearly

D. Team Membership

ISP's/IFSP's are developed by a team. This team should include all persons involved in the life of the individual. Some examples of team members include, but are not limited to the following:

> The individual

> The parent/guardian

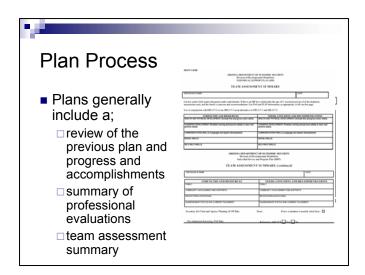> Case Manager/Support Coordinator

> Direct Support Professionals

> Friends, Family, Advocates, Neighbors and others as invited by the individual and their family.

Meetings are generally held at least annually, the frequency of meetings is usually determined by the team and the Division. Reviews of the plan may be held throughout the year. Team members have the right to call a teaming at any time.

The ISP/IFSP is a living document. The team may agree to make changes to the plan throughout the year. The changes are documented in writing. Any team member can propose changes to the plan. Depending on the change, a meeting may be held or all team members may be contacted. The individual/responsible person must agree and sign-off on the change.

Throughout this training you will see an example of forms or components used in most planning processes

Plan Process

- Plans generally include a;
  - review of the previous plan and progress and accomplishments
  - summary of professional evaluations
  - team assessment summary

E. Process
(This is the time during training the trainer should provide a copy of their agency's planning tool, to give participants a chance to review the plan.)

We are now going to talk about sections of the ISP document that may be used for DD services.

The ISP process may be facilitated by many different people, but should focus and be primarily driven by the focus person and their family.

Generally the ISP plan starts with a review of the previous plan, data, and accomplishments or changes.

The Summary of Professional Evaluations section is an overview of medical treatments or other professional evaluations like speech therapy evaluation, dental exam, and so forth.

The Team Assessment Summary or the Personal Profile is a review of the individual's strengths and needs. It gives us a picture of the individual's capacities, resources, challenges and supports. This should be primarily driven by individual/family.

The Preferences and Visions of the future section should indicate what motivates the individual, what are their hopes and plans for the future.

The Action Plan contains what the individual wants and needs to work on to gain skills or independence. This is where the team documents specific teaching plans, objectives or outcomes. Division-funded outcomes or behavior building plan outcomes must be listed here. Additionally, this may include academic goals, self-help goals, or other goals the individual/family have identified to work on privately or with other agencies.

The Action Plan Part II indicates the team agreements and assignments spells out what the specific assignment is, the person responsible, and the time line to complete that assignment.

The Support Information area of the ISP has a Medication section that contains information on the current medications, dosages, side-effects, and purpose of the medication. The Adaptive

Equipment section documents needs regarding adaptive equipment which could include glasses, walkers, canes, wheelchairs, etc.
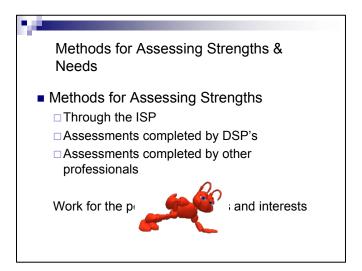
The Exceptions to Residential Licensing section address permissions for individuals living in a licensed setting (i.e. group home, developmental home). When rules and regulations were developed for group home settings, the assumption was made that certain safe guards were necessary to protect consumers from harm. This form asks the team to review the consumer's skills and make choices about supervision, access to chemicals and medications. Staff should be aware of the teams choices for each consumer, this is important for the health and safety of those we support.

The ISP Spending Plan reviews the individual's assets and monthly expenditures. For individuals living in a family home, this form is not commonly needed.

The Risk Assessment may include several pages, each identifying a health and safety risk, as well as the supports needed to address the concerns.

A Cover Sheet is completed and signed by all team members, showing they attended the meeting. A space is available to check if you agree or disagree with the plan. If you disagree or have concerns regarding the plan, the planning meeting is the preferred and best time to raise concerns, disagreements, and offer alternative solutions.

Trainer's Note: Some people and agencies will wait to mark if they agree or disagree until the written plan has been received. Please remember, the cover sheet also serves as an attendance sheet, so people do need to sign their attendance.

Methods for Assessing Strengths &
Needs

- Methods for Assessing Strengths
  - □ Through the ISP
  - □ Assessments completed by DSP's
  - □ Assessments completed by other
    professionals

  Work for the p[...] and interests

F. Needs Assessment

When developing goals or objectives for the person it is sometimes necessary to complete an assessment of their current abilities, strengths and needs.

There are many different methods for assessing a consumers strengths and needs, some are formal and some are very informal. All methods have value. Sometimes it's as simple as going through the strength and needs section of the ISP and getting input from the individual and family members. Sometimes it's an assessment completed by the Direct Support Professionals that work with the person. These assessments can be completed by therapists, doctors or even psychologists.

It is important that we look to the persons strengths and interests, when doing assessments or developing goals. Formal assessment information gets summarized on the Summary of Professional Evaluations page of the ISP.

Through the planning process, the individual and the team may identify certain services to support the person's goals. Common Home and Community Based Services (HCBS) may include:

Respite: Supervise and care for an individual in order to relieve the primary caregivers.

Attendant Care: Assist a person to attain or maintain safe and sanitary living conditions and/or maintain personal cleanliness and activities of daily living. An attendant care agreement is created specific for each individual, outlining the DSP's tasks.

Habilitation: Teach and assist a person in learning a skill.

Trainer's Note: The Division offers many other services and supports. Respite, attendant care, and habilitation are the most common DSPs will be providing.

Developing Measurable Objectives

- Objectives must include the following:
  - Person
  - Conditions
  - Statement of observable, measurable behavior
  - Criteria
  - The date the team reasonably expects the skill to be acquired

G. Developing Outcomes

Once the assessments have been completed the team is going to develop objectives or outcomes. The objectives and outcomes need to be easily understood by all team members, and directed by the individual/family. An objective is a measurable goal that is very precise in its documentation of progress and leaves little room for interpretation. An outcome is what we want to see the consumer do as an end result and does not necessarily measure progress along the way. For the purpose of this training we will focus on objectives. These objectives must include the following:

Person: This can be the person's first name of nickname.

Conditions: This reflects specifically what criteria performance level we expect the individual to perform the task.

Measurable: This reflects the behavior; skill or task the person will do when the learning process is complete and they have mastered the skill. An objective should never be worded "will learn" or "will be able to". It must be something that is observable: (i.e. you can see or hear it) and measurable (i.e. you can count when it happens).

Criteria: How do we know a person has achieved a skill? There are many ways to write the criteria statement.

Date: The date the team reasonably expects the skill to be acquired. Most objectives are set up to be completed or achieved by the following annual ISP. Objectives can include several steps to keep the learning going throughout the year.

If the team has chosen to use outcomes when the consumer is receiving services other than habilitation, the outcome statement should document what team wants the end result to be.

The Use of Teaching Plans

- Teaching plan must include the following components (DDD rules):
  - How
  - When
  - By whom
  - Method for data collection
  - The procedure that will be followed should the objective/outcome be completed or if progress is not made as planned

H. Teaching Plans

Once the objective/outcome has been written it is our responsible to complete a written teaching plan. This teaching plan must include the following components required by rule:
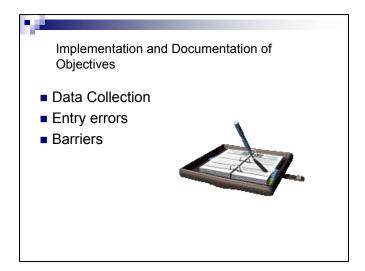
How, when and by whom the objective/outcome will be implemented. On the teaching plan you will see a section marked Frequency of Implementation. This section tells us when the objective/outcome is to implemented. The section marked Staff Responsible for Implementation tells us by whom the objective/outcome will be implemented. The section marked Methodology, should spell out how the objective/outcome will be implemented. This section should be very simple and easy for anyone to understand how to implement the objective/outcome.

The method to be used to record data relative to progress. Do we track progress by marking down a +, or -, yes or no or do we use some other method?

The procedure that will be followed should the objective/outcome be completed or if progress is not made as planned. This information is also included in the teaching strategy in the sections marked "If Progress in Not Made" and "If Criteria for Success is achieved." When an individual is not making progress we have a couple of options, we can increase the amount of assistance, we can break the task into smaller steps, we can change or discontinue an objective, or we can change the criteria.

Changing the number of steps or the level of assistance has a greater impact on the individual's progress. If the criteria for success has been met we again have a couple of options, we can decrease the amount of assistance offered, we can increase the criteria or percentage, discontinue the objective, make it informal, or change the objective entirely.

It is essential that staff understands and implement all objectives/outcomes. Failure to do so could result in a contract action, because after all what are paid to do but teach. We are also required to submit a copy of the teaching strategy to the case manager/Support Coordinator within 14 days of the ISP.

Implementation and Documentation of Objectives

- Data Collection
- Entry errors
- Barriers

I. Implementation of Objectives

It is vital that staff implement and document the implementation of ISP objectives and outcomes. In most residential settings we are paid to implement objectives through "Habilitation". Habilitation means we are going to work with or teach someone a skill. The objectives and outcomes are how we document that teaching. Failure to implement these objectives/outcomes is failure to fulfill our contract. Not implementing objectives is also harmful to the person you serve. When implementing these objectives/outcomes we need to ensure that we are taking data as indicated by the teaching plan.

If you make an error charting data, you should use a proper correction – draw one line through the error, initial the error and write the correct information above or below the correction.
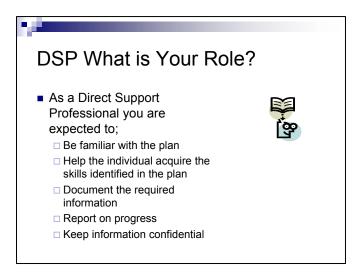
Barriers are simply that a barrier to the implementation of the objective or outcome. Some examples of barriers: the consumer was ill, they were on a home visit, there was a special outing or activity, the consumer refuses to participate, the materials needed to implement the objective were not available (the washer was not working etc.). When barriers occur – staff must document the barrier.

Monthly Progress Reports

- At the end of each month we are required to submit a progress report detailing each individuals progress on their objectives-outcomes

J. Monthly Progress Reports

At the end of each month we are required to submit a progress report detailing each individuals progress on their objectives/outcomes. This report is to be completed and sent to the case manager by the 10th working day of the month. This report summarizes the data collected by staff in a percentage format or as other wise specified by the teaching plan. It also documents the status of team agreements and assignments as indicated by the ISP. We are required to report on the status of assignments that are assigned to us, and are due during the month of the report. If the assignment reads on going, we must report on the assignment each month.

DSP What is Your Role?

- As a Direct Support Professional you are expected to;
  - Be familiar with the plan
  - Help the individual acquire the skills identified in the plan
  - Document the required information
  - Report on progress
  - Keep information confidential

K. Role of the Direct Support Professional

As a Direct Support Professional you are expected to:

Be familiar with the plan

Help the individual acquire the skills outlined in the plan, *as directed by your supervisor*

Document the required information

Report on progress to the designated person

Keep information confidential

Remember, you are not in charge of the plan – but will carry out any activities or assignments as requested by your supervisor in cooperation with the ISP team.

Methods of Supporting Learning

- Daily routine

- Prompts, cues and fading

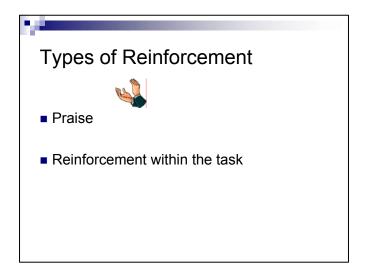- Modeling

- Chaining

L. Methods of Teaching
Look for opportunities in the daily routine to support learning.

Use a variety of cues and prompts, fade the use of cues as it becomes appropriate.

Use modeling, show individuals how to do something by showing them.

Chaining – this is showing how do something in steps. You can do forward chaining or backward chaining. Forward chaining is teaching the first step first. For example, if you were teaching a person how to do laundry, you would teach them how to sort clothes first. This would be forward chaining.   If doing backward chaining you teach the last step first so you would teach the person to fold the clean laundry, then add the previous step – drying the clothing.

Additional positive teaching techniques are provided in the Article 9 packet.

Types of Reinforcement

- Praise

- Reinforcement within the task

M. Reinforcement

Positive reinforcement increases the likelihood of positive behaviors and outcomes. A reinforcer is something a person wants and is willing to work for. The best way to identify reinforcers is to get to know the person.

Some examples of positive reinforcement include:

Praise – Everyone loves positive comments about themselves, although different types of praise work for different individuals. For example, loud clapping may work someone with Down syndrome but may very upsetting for someone with Autism who is sensitive to noise.   We should use the "What Works" for ideas for reinforcement within the DDD system and any information given in the "Present Levels of Educational Performance" section of the IEP within the school system.

Social Reinforcers – Including praise, social reinforcement includes high fives, hugs, smiling, group recognition, etc.

Reinforcement within the Task – Reinforcement builds self esteem. Lets say you have an individual who doesn't like to take a shower. So you offer a contingency statement: "After you take a shower, we will go to the store and get a pop." In this case the reinforcer is a pop. If you make a big deal about how great the person smells, you can eventually fade out the other reinforcer of the pop. The person will do the task because of how great he/she smells.

Reinforcers need to be "extras", meaning they are above and beyond a person's human rights. Giving someone dinner cannot be a reinforcer. Picking the restaurant or getting dessert may be reinforcers.

Principles of Caregiving
Developmental Disabilities

SECTION VII — INTRODUCTION TO THERAPIES

Speech Therapy

- What is speech therapy?
  - The active treatment of a speech disorder
- Provides support with
  - Development of speech sounds
  - Language problems
  - Voice and fluency problems

A. Speech

Speech therapy is the active treatment of a speech disorder and oral-motor muscles, which may include feeding and movement of the mouth.

When an adult is concerned about a child's speech or language development it's important that they be encouraged to seek professional advice. Speech-language pathologists are professionals who evaluate and provide intervention for adults and children with a wide variety of communication disorders. These may include development of speech sounds, language problems, and voice and fluency problems.

Speech therapists may also evaluate the need for adaptive equipment. This can include things like augmentative communication devices, picture exchange systems, etc.

Speech-language pathologists are located in public schools, hospitals, clinics and private practice. Speech therapy may be a service provided by schools and/or the Division of Developmental Disabilities.

The speech pathologist or therapist meets with the individual, completes an evaluation and develops goals or objectives to further the individual's speech abilities. Direct support professionals are to carry out the objectives to support this person's progress.

What does the DSP do to support Speech?

- You have a responsibility to implement goals as they are written

- Model good language skills

The speech pathologist is legally responsible for the client's progress toward the goals and objectives stated. His/her directives must be carried out specifically. In all cases, refer to your specialist when you have concerns. Never change any specified activities without the therapist's knowledge and approval.

These are the activities you as a Direct Support Professional can do to promote the speech goals of the individual:

First and foremost be a good role model - Speech and language skills need to be consistently modeled in all activities. Modeling must be in the form of correct grammar and pronunciation.

Examples: Incorrect pronoun usage – "This is her." Correct – "This is she."

Double negatives – "He don't not do that." Correct—"He can't do that."
There is a story about a man from the east coast who called his family friend in Phoenix. He was excited to tell him about his son who was stationed at Fort Hug-a-chucka in Cock-a-see county, Arizona. The man from Phoenix had two choices. He could laugh and embarrass his friend or he could model the correct pronunciations and continue the conversation. The man from Phoenix state, "I would love to visit your son at Fort Huachuca, down in Cochise county. I'll call him tonight."

Modeling continues the flow of conversation without calling attention to the speaker.

The general population judges people on their communication skills. If they "sound" different, people think less of them or think that they are not very intelligent.

Trainer's Note: Address the need to model culturally appropriate dialect.

Elements of Good Speech

- Show Your Interest
- Information Talk
- Limit Closed Questions
- Indirect Correction

We're now going to discuss four techniques used in assisting a person to develop language skills.

ELEMENTS OF GOOD SPEECH

Show your interest – get down on the child's or adult's level, pay close attention to what the person is doing, establish eye contact.

Use "information" talk – describe what someone is doing or seeing as they are doing it. This should be done without interrupting the activity, and it teaches the individual words that go with his/her actions. It gives them the correct words and sentences without being corrected.

Limit closed questions-closed questions require only a one or two word answer and have only right or wrong answers. Ask open ended questions – What did you do at recess? vs Did you play ball at recess? What did you have for dinner? vs Did you have pizza for dinner? Etc.

Indirect correction- let the person hear the correct sounds or words for what they are saying without stopping the flow of conversation. For example, if the person says words incorrectly, don't say no and repeat it. That gives the child the impression that the context of what they are saying is incorrect. Just repeat the words correctly.

Trainer Notes

Review the 4 areas of good speech and have students give examples of when they might use these techniques, reminding them that these techniques are good to use all the time and with anyone.

Physical Therapy

- What is physical therapy?
  - The treatment of a physical disorder or disability involving the large muscles.
- Provides support with;
  - Physical function – gross motor skills
  - Quality of life as it relates to movement and health
  - Evaluate need for adaptive equipment

B. Physical

Physical therapy is the treatment of a physical disorder or disability involving the large muscles (gross motor).

Physical therapy provide services to people who have impairments, functional limitations, disabilities or changes in health status from injury, disease or other causes. It involves gross motor skills or the large muscles that would be used to crawl, walk, jump, ride a bike, throw a ball, etc.

The therapist provides support with physical function – supporting people to use their body and their muscles – teaching someone how to walk again after a stroke, helping a child to develop their large muscles to do things like sitting up, crawling, navigating stairs or even riding a bicycle. These are all issues relating to the quality of life as it relates to movement and health.

The physical therapist also evaluates the need for adaptive equipment. This can include things like – wheelchairs, standers, bathing equipment, lifting devices and so forth.

Physical therapists are located in public schools, hospitals, clinics and private practice. Physical therapy may be a service provided by schools and/or the Division of Developmental Disabilities.

A physical therapist could also work on overall wellness and physical fitness, this could include therapeutic massage.

Protect the person's well-being – stay within the recommended activities developed by the therapist.   Doing activities on your own or modifying the activity could cause injury to the person.

 You have a responsibility to implement goals as they are written.

Model good body mechanics, lift with your knees, demonstrate good posture and so forth. If assisting the person to do an activity, demonstrate it first.

Show your interest – be encouraging, acknowledge success, use praise and rewards.

Encourage physical activities that support the goals – sometimes doing activities without pointing out that you are doing the activity is more fun. For children, making a game out of the activity can be very motivating. You could also put the activity to music to help motivate someone.

Be consistent – physical or muscle memory is learned through repetition. It's important to work consistently towards goals.

Occupational Therapy

- What is occupational therapy?
  - The treatment of a physical disorder or disability that involves the small muscles
- Provide support to;
  - ☐ Achieve or regain a higher level of independence in fine motor activities
  - ☐ Assist with sensory integration techniques
  - ☐ Be positive and use modeling

C. Occupational

Occupational therapy is the treatment of a physical disorder or disability involving the small muscles (fine motor). Occupational therapy provides services to people who have impairments, functional limitations, disabilities or changes in health status from injury, disease or other causes.

The therapist provides support to achieve or regain a higher level of independence - supporting people to use their fine muscle skills like teaching someone to eat, hold a pencil correctly, and other daily living skills like shaving or tooth brushing.

These may include activities that promote crossing mid-line which means using one hand or another to cross the mid line of the body. It could also include sensory processing which is doing activities that increase an individual's awareness of their body, such as joint compression, brushing, or using weight jackets. Other activities would be learning to cut with scissors, picking up small objects like coins or beans. Zipping, buttoning or snapping can be difficult for some individuals and activities may center around learning to do this.

Once again, use modeling and be positive in your encouragement as some of these activities can be very frustrating when learning how to do them.

The occupational therapist may also evaluate the need for adaptive equipment. This can include things like – pencil grips, handles, special eating utensils, etc.

Occupational therapists are located in public schools, hospitals, clinics and private practice. Occupational therapy may be a service provided by schools and/or the Division of Developmental Disabilities.

Both fine and gross motor skills overlap each other as the muscles in the body all work together. Some OT and PT activities may be similar.

> **The DSP role in Occupational Therapy**
>
> - Implement goals as they are written
> - Model good body movements
> - Be positive and use praise
> - Encourage physical activities that support the goals
> - Be consistent

You have a responsibility to implement goals as they are written.

Model good body movements.

Be positive – be encouraging, acknowledge success, use praise and rewards.

Encourage physical activities that support the goals – sometimes doing activities without pointing out that you are doing the activity is more fun. If you are working on fine motor skills think of activities like beading a necklace or playing a game with small parts that encourage the same skills. There a many different fun games and activities that accomplish the same goal. Be creative in your approach and clear all activities with the therapist.

Be consistent – don't skip days or times that you are supposed to implement the goals.

Music Therapy

- What is music therapy?
  The use of music to treat various deficits in communication skills or other functional limitations

- The DSP's role in music therapy
  - Follow instructions of therapist
  - Use positive encouragement

D. Music

Music therapy is the use of music to treat various deficits in communication skills or other functional limitations.

It is motivational and opens up opportunity for learning in a variety of areas. Music therapy creates positive social experiences that may not otherwise be available to people with disabilities. It aids in developing self-awareness, awareness of others, awareness of their environment, physical skills, it also can help achieve other goals.

Here are some examples of what the DPS might be asked to do:

Sing songs with the individual which will help the individual express his/her feelings.

Help an individual learn to play piano for the purpose of improving fine motor skills.

Use musical instruments to improve movement activities.

Sing songs to improve the individual's ability to speak.

It is important to be aware that individuals participating in music therapy may develop their skills in music but this is not the primary intention of music therapy. The music therapist is more interested in the affect it has on the individual's physical, psychological and social functioning. The therapist may use music to motivate an individual to participate in PT, OT or Speech therapy activities.

Some individuals receive habilitation through the Division of Developmental Disabilities that includes music therapy.

Art Therapy

- What is Art Therapy?
  The use of different art forms to assist individuals in a variety of disorders or problems

- The DSP's role in Art Therapy
  □ Assist in art projects
  □ Be positive – praise often
  □ Follow directions of therapist

E. Art

Art therapy uses different art forms to assist individuals in a variety of disorders or problems. It uses art to assist individuals in reconciling emotional conflicts fostering self-awareness, developing social skills, managing behavior, solving problems, reducing anxiety, aiding reality orientation, increasing self-esteem, and aids in development of fine/gross motor skills.

The DSP may be asked to carry out different art projects based on the recommendations of the therapist.

Examples of activities a DSP may be engaged in: color and cut out pictures to assist in development of fine motor skills; use tactile materials to reinforce academic skills and sensory awareness; draw pictures to help express thoughts and ideas when unable to verbally communicate.

Art therapy may be incorporated to support someone with their behavioral needs, or used as a technique in another therapy (such as occupational therapy).

Recreational Therapy

- What is Recreational Therapy
  - The use of recreation to improve physical, cognitive and social abilities

- The DSP's role in Recreational Therapy
  - Carry out activities as directed by the therapist
  - Be encouraging and make it fun

F. Recreational

Recreational therapy aids in improving physical, cognitive and social abilities. Some recreational activities may include; adaptive sports, aquatic therapy, animal assisted therapy, sensory stimulation, and community integration skills.

The DSP may be asked to carry out specific activities as directed by the therapist.

Some examples include – taking the person swimming, participating in team sports, taking the person to a therapeutic horseback riding session, etc.

Recreational therapy is often used as a technique with another therapy (such as physical therapy).

Individual/Family/Group Counseling

- What is counseling?
  The treatment of an individual or family to learn new ways of behaving of interacting with others

- The DSP's role in counseling.
  □ Follow specific directions of therapist

G. Individual/Family and Group Therapy

Counseling is focused on helping the client/family learn new ways of behaving or interacting with others. Counseling is typically provided by master's level behavioral health professionals after a comprehensive assessment.

It may involve new ways of thinking about one's own self, feelings, one's family, and relationships with others. It emphasizes a person's strengths or assets.

It sometimes examines memories, or past events, but almost always focuses on current issues.

The DSP role in counseling is only in carrying out activities directed by the therapist.

Counseling may be provided through the school, private health plan, State behavioral health services, or private pay.

If an individual is receiving services from the Division of Developmental Disabilities and a behavioral health authority, it is often documented in the person's annual plan. In some instances, additional behavioral support may be provided by the behavioral health authority.

Principles of Caregiving
Developmental Disabilities

SECTION VIII — ARTICLE 9

**Article 9 requires a certified instructor.
To become a certified instructor, please call your Division of Developmental
Disabilities District training coordinator.
As a certified instructor, you will be provided with the Statewide Minimum
Curriculum and instructor materials.**

Principles of Caregiving
Developmental Disabilities

SECTION IX — INCIDENT REPORTING

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│ ■ ■                                         │
│ ■                                           │
│        Examples of Incident Reports         │
│        ■ General incident reports           │
│          document:                          │
│            □ Any non-serious accidents      │
│            □ Any non-serious injuries       │
│            □ Any non-serious illnesses      │
│            □ Medication errors              │
│            □ Home disturbances              │
│                                             │
│                   *Is not an all-inclusive list │
│                                             │
└─────────────────────────────────────────────┘
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A. Incident Reports

1. Purpose

The purpose of the incident report is to record and notify DDD, parent/guardian, and identified parties of an incident or emergency measure. Incident reports may then be used to look for patterns and solutions.

2. Examples

Any non-serious accidents – a person falls (documentation of falls may prevent allegations of abuse, because it is documented that something happened in case bruises show up at a later date)

Any non-serious injuries – a scratch or bruise

Any non-serious illnesses – has the flu, cold or other signs of illness

Medication errors – when a person receives their medication late, does not receive it at all or is given the wrong medication. (this does not include documentation errors on the medication log, if they have no impact on the person).

Disturbances - minor aggressions, disagreements between individuals

3. Contents

It is vital that all the information is *clear* and *objective*. While the format for that report will vary from agency to agency, it is important that the affected employee is the writer of the report, and should refrain from giving an opinion as this is subjective. Describe the incident in the manner in which it was observed. Begin with what happened before the incident, what occurred during the incident and ensure the report has a conclusion including any follow up procedures required.

Include all individuals involved in the incident. Use the affected person's name and when referencing other people be sure to use initials to ensure confidentiality. All employees' names should be used but indicate in parenthesis that the person is a staff member. Use initials for other outside individuals such as members of the community or staff. Spelling and punctuation must be correct before submitting the report.

4. Review and Routing

General Incidents are recorded and reported to most funding sources (for example, the Division of Developmental Disabilities), the consumer's parent or guardian, and your agency administrative staff. This reporting is usually done by mail, unless otherwise specified. It is important that we document that this reporting occurred.

- Serious incident reports document:
  - Alleged abuse / neglect
  - Death
  - Missing person
  - Community disturbances or complaints
  - Hospitalization, the intervention of a medical practitioner or emergency medical care
  - Significant damage to property

  Is not an all-inclusive list

B. Serious Incident Reports (SIR)

A SIR is completed in the following cases:

Alleged abuse / neglect – any allegation of abusive treatment.

Death

Missing person -A person who is missing must be reported to law officials and your funding source as soon as the person is determined to be missing.

Community disturbances or complaints involving the person(s) you work with or with the residential setting (includes the neighbors making complaints).

Hospitalization - the intervention of a medical practitioner or emergency medical care in response to a serious illness, injury, medication error or suicidal behavior or attempts.

Significant damage to the property.

1. Contents

It is vital that all the information is *clear* and *objective*. While the format for that report will vary from agency to agency, it is important that the affected employee is the writer of the report, and should refrain from giving an opinion as this is subjective. Describe the incident in the manner in which it was observed. Begin with what happened before the incident, what occurred during the incident and ensure the report has a conclusion including any follow up procedures required.

Include all individuals involved in the incident. Use the affected person's name and when referencing other people be sure to use initials to ensure confidentiality. All employees' names should be used but indicate in parenthesis that the person is a staff member. Use initials for other outside individuals such as members of the community or staff. Spelling and punctuation must be correct before submitting the report.

2. Procedures

Whenever an incident occurs, whether it's a general incident, serious incident or an emergency measure it is vital that you ensure the safety of the individual and staff. Once that is done, the staff involved with the incident will write the incident report.

If this is a serious incident, staff will immediately contact their supervisor.

Incident reports must be written before the end of a shift or work period and turned into the supervisor at the earliest possible opportunity.

Serious Incidents are recorded and reported to the funding source, the individual's parent or guardian, and your agency's administrative staff. In the case of a Serious Incident for the Division of Developmental Disabilities, this reporting is to be done immediately which is defined as "the first allowable opportunity that does not place the consumer at risk, not to exceed 24 hours." It is important that we document who was notified and the date and time of that notification.

3. Review and Routing
Each agency will designate different people to review incident reports prior to their submittal, it is important that you know the process specific to your agency.

4. Special Circumstances
When an incident occurs that requires immediate reporting, but it is after business hours, DDD has the following contact numbers:

District 1: 602-375-1403
District 2: 520-745-5588
District 3: 928-773-2976
District 5: 520-723-4151
District 6: 520-458-7166

C. Emergency Measures

1. When to Use
Emergency Measures are not permitted by all funding sources. Emergency Measures are to be used only in the event that an individual engages in a sudden, unanticipated and severe aggressive or destructive behavior endangering the health and/or safety of the individual or another person and substantial damage to individual, your agency's or state property.
An Emergency Measure is the use of a physical restraint such as;

A standing restraint; a seated restraint; physical escorts

These are Client Intervention Training (CIT) level II techniques which will be thoroughly covered by your CIT instructor, and may only be used by staff certified in CIT.

As we discussed in Article 9 before, we use emergency measures we need to ensure that -
It is used only when other non-aversive techniques have been ineffective or are inappropriate.)
Use the least amount of intervention necessary—block only or use standing restraint before use of seated restraint.
Use concurrently with the uncontrolled behavior—when they are calm they must be released; no holding them down and making them apologize.
Be appropriate to the situation—no seated restraint on hot pavement.
By trained staff (certified in CIT)

Please be sure you document the other techniques used prior to the restraint in the written report.

2. Procedures
Whenever an emergency measure occurs, it is vital that you ensure the safety of the individual and staff. Once that is done, the staff involved with the incident will write the incident report.
In an emergency measure report it is important to describe the behavior thoroughly, with details about physical interaction, simply stating the person was aggressive is not enough.

Also, it is important to note what other interventions were tried if applicable prior to the restraint.

3. Review and Routing

Each agency will designate different people to review incident reports prior to their submittal, it is important that you know the process specific to your agency. Emergency measures are reported to DDD, the individual's parent or guardian, your agency's administrative staff and to the Program Review Committee (PRC) and the Human Rights Committee (HRC). This reporting is to be done immediately which is defined as "the first allowable opportunity that does not place the consumer at risk, not to exceed 24 hours." It is important that we document who was notified and the date and time of that notification.

4. Special Circumstances

When an incident occurs that requires immediate reporting, but it is after business hours, DDD has the following contact numbers:

District 1: 602-375-1403
District 2: 520-745-5588
District 3: 928-773-2976
District 5: 520-723-4151
District 6: 520-458-7166
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Practical Practice
- Watch the following event

  □ Determine if the event needs an incident report

  □ What sort of incident report is necessary?

D. Practical Practice
Please complete a report on the incident you have just witnessed. Be prepared to answer questions about what you saw and what you reported.

Documentation Tips:
Use blue or black ink. Do not use white out or pencil.
Remember incident reports are legal documents.
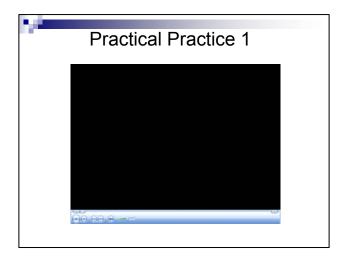Date all reports with month/day/year format.
Use initials to refer to *other* consumers in the incident. Use names for other staff and the consumer the incident report is about.
Document observable behaviors; do not include your opinion or interpretation of event. (For example, write "Johnny hit the wall and swung his arm at staff and roommate, L.M." instead of "Johnny was mad and had a behavior.")
Be sure to include description of what was happening prior to the incident, the incident itself, and what happened afterwards.
Follow agency procedure and reporting policy.

Instructor note: Ask students to identify if this was a general incident, a serious incident or an emergency measure. Ask questions about who should be notified, what should be written down. Be creative with your questions – this should be a learning, but fun experience.

Practical Practice 1

Please complete a report on the incident you have just witnessed. Be prepared to answer questions about what you saw and what you reported.

Instructor note: Ask staff to identify if this was a general incident, an serious incident or an emergency measure. Ask questions about who should be notified, what should be written down. Be creative with your questions – this should be a learning, but fun experience.

Principles of Caregiving
Developmental Disabilities

SECTION X — CLIENT INTERVENTION TECHNIQUES
(CIT)

CIT requires a certified instructor.
To become a certified instructor, please call your Division of Developmental Disabilities District training coordinator.
As a certified instructor, you will be provided with the Statewide Minimum Curriculum and instructor materials.

Principles of Caregiving
Developmental Disabilities

SECTION XI — DSP CODE OF ETHICS

Person Centered Supports

- As a DSP, my first allegiance is to the person I support and I must;
  - Recognize that each person must direct his or her own life
  - Commit to person-centered supports as best practice
  - Provide advocacy
  - Honor the personality, preferences, culture and gifts
  - Focus first on the person

A. Person-Centered Supports

As a DSP, my first allegiance is to the person I support; all other activities and functions I perform flow from this allegiance. As a DSP, I will -

Recognize that each person must direct his or her own life and that the unique social network, circumstances, personality, preferences, needs and gifts of each person I support must be the primary guide for the selection, structure, and use of supports for that individual.

Commit to person-centered supports as best practice.

Provide advocacy when the needs of the system override those of the individual(s) I support, or when individual preferences, needs or gifts are neglected for other reasons.

Honor the personality, preferences, culture and gifts of people who cannot speak by seeking other ways of understanding them.

Focus first on the person, and understand that my role in direct support will require flexibility, creativity and commitment.

Discussion—*You are working with a 30 year old man who has a seizure disorder and falls down whenever he has a seizure. Has a part-time job and wants to walk the 1 ½ blocks to work. His guardian thinks it would be too dangerous for him to walk. There is nothing in his plan that addresses this. You have been invited to the team meeting and he wants you to advocate for him. What would you do?*

Promote Physical & Emotional Well-Being

■ As a DSP, I am responsible for supporting the emotional, physical, and personal well-being of the individuals receiving support . I must;
  □ Develop a relationship
  □ Assist individuals to understand their options
  □ Promote and protect well-being
  □ Know and respect values
  □ Challenge others to be supportive
  □ Be a vigilant reporter
  □ Consistently address challenging issues

B. Promoting Physical and Emotional Well-Being

As a DSP, I am responsible for supporting the emotional, physical, and personal well-being of the individuals receiving support. I will encourage growth and recognize the autonomy of the individuals receiving support while being attentive and energetic in reducing their risk of harm. As a DSP, I will –

Develop a relationship with the people I support that is respectful, based on mutual trust, and that maintains professional boundaries.

Assist the individuals I support to understand their options and the possible consequences of these options as they relate to their physical health and emotional well-being.

Promote and protect the health, safety, and emotional well-being of an individual by assisting the person in preventing illness and avoiding unsafe activity. I will work with the individual and his or her support network to identify areas of risk and to create safeguards specific to these concerns.

Know and respect the values of the people I support and facilitate their expression of choices related to those values.

Challenge others, including support team members (e.g. doctors, nurses, therapists, co-workers, family members) to recognize and support the rights of individuals to make informed decisions even when these decisions involve personal risk.

Be vigilant in identifying, discussing with others, and reporting any situation in which the individuals I support are at risk of abuse, neglect, exploitation or harm.

Consistently address challenging behaviors proactively, respectfully, and by avoiding the use of aversive or deprivation intervention techniques. If these techniques are included in an approved support plan I will work diligently to find alternatives and will advocate for the eventual elimination of these techniques from the person's plan.

Integrity and Responsibility

- As a DSP, I will;
  - Be conscious of my own values and how they influence my professional decisions.
  - Maintain competency in my profession.
  - Assume responsibility and accountability for my decisions and actions.
  - Actively seek advice and guidance
  - Recognize the importance of modeling valued behaviors
  - Practice responsible work habits

C. Integrity and Responsibility

As a DSP, I will support the mission and vitality of my profession to assist people in leading self-directed lives and to foster a spirit of partnership with the people I support, other professionals, and the community. As a DSP, I will -

Be conscious of my own values and how they influence my professional decisions.

Maintain competency in my profession through learning and ongoing communication with others.

Assume responsibility and accountability for my decisions and actions.

Actively seek advice and guidance on ethical issues from others as needed when making decisions.

Recognize the importance of modeling valued behaviors to co-workers, persons receiving support, and the community at-large.

Practice responsible work habits – be punctual, show up – people you support have a relationship with you and take it personally when you don't show up. The manner in which you dress reflects how you think and feel about the people you support. You want to model appropriate physical appearance with your personal hygiene and your dress.

Confidentiality

- As a DSP, I will safeguard and respect the confidentiality and privacy of the people I support. I must;
  - Seek information directly from those I support .
  - Seek out a qualified individual who can help me clarify situations where the correct course of action is not clear.
  - Recognize that confidentiality agreements with individuals are subject to state and agency regulations.
  - Recognize that confidentiality agreements with individuals should be broken if there is imminent harm to others or to the person I support.

D. Confidentiality

As a DSP, I will safeguard and respect the confidentiality and privacy of the people I support.

As a DSP, I will;

Seek information directly from those I support regarding their wishes in how, when and with whom privileged information should be shared.

Seek out a qualified individual who can help me clarify situations where the correct course of action is not clear.

Recognize that confidentiality agreements with individuals are subject to state and agency regulations.

Recognize that confidentiality agreements with individuals should be broken if there is imminent harm to others or to the person I support.

Discussion—*You are the one-on-one aide for a child in the elementary school. As you arrive at school one morning you notice several school employees huddled together in deep conversation. They notice you and invite you over and proceed to tell you about how poorly Johnnie, a student with cerebral palsy, did on the AIMS test. What should you do?*

Justice, Fairness and Equity

- As a DSP, I will promote and practice justice, fairness, and equity for the people I support. I will;
    - □ Help the people I support use the opportunities and the resources of the community available to everyone.
    - □ Help the individuals I support understand and express their rights and responsibilities.
    - □ Understand the guardianship or other legal representation of individuals I support.

E. Justice, Fairness and Equity

As a DSP, I will promote and practice justice, fairness, and equity for the people I support and the community as a whole. I will affirm the human rights, civil rights and responsibilities of the people I support. As a DSP, I will;

Help the people I support use the opportunities and the resources of the community available to everyone.

Help the individuals I support understand and express their rights and responsibilities.

Understand the guardianship or other legal representation of individuals I support, and work in partnership with legal representatives to assure that the individual's preferences and interests are honored.

Respect

- As a DSP, I will respect the human dignity and uniqueness of the people I support. I will;
  - Seek to understand the individuals I support.
  - Honor the choices and preferences.
  - Protect the privacy.
  - Uphold the human rights.
  - Interact in a respectful manner.
  - Recognize and respect the cultural context.
  - Provide opportunities and supports that help the individuals I support be viewed with respect and as integral members of their communities.

F. Respect

As a DSP, I will respect the human dignity and uniqueness of the people I support. I will recognize each person I support as valuable and help others understand their value. As a DSP, I will;

Seek to understand the individuals I support today in the context of their personal history, their social and family networks, and their hopes and dreams for the future.

Honor the choices and preferences of the people I support.

Protect the privacy of the people I support.

Uphold the human rights of the people I support.

Interact with the people I support in a respectful manner.

Recognize and respect the cultural context (e.g. religion, sexual orientation, ethnicity, socio-economic class) of the person supported and his/her social network.

Provide opportunities and supports that help the individuals I support be viewed with respect and as integral members of their communities.

Discussion—*You are providing in-home care to Susie, who is 12 years old. While you are there she has diarrhea and has an accident in her pants. You and Susie are doing a puzzle together in the front room when her parents arrive home. They come into the front room and you tell them about your time with Susie, including the accident. What is wrong with this situation?*

Relationships

- As a DSP, I will assist the people I support to develop and maintain relationships.   I will;
  - Advocate for the people I support .
  - Assure that people have the opportunity to make informed choices.
  - Recognize the importance of relationships.
  - Separate my own personal beliefs and expectations regarding relationships from those desired by the people I support based on their personal preferences.
  - Refrain from expressing negative views, harsh judgments, and stereotyping of people close to the individuals I support.

G. Relationships

As a DSP, I will assist the people I support to develop and maintain relationships. As a DSP, I will;

Advocate for the people I support when they do not have access to opportunities and education to facilitate building and maintaining relationships.

Assure that people have the opportunity to make informed choices in safely expressing their sexuality.

Recognize the importance of relationships and proactively facilitate relationships between the people I support, their family and friends.

Separate my own personal beliefs and expectations regarding relationships (including sexual relationships) from those desired by the people I support based on their personal preferences. If I am unable to separate my own beliefs/preferences in a given situation, I will actively remove myself from the situation.

Refrain from expressing negative views, harsh judgments, and stereotyping of people close to the individuals I support.

Self-Determination

- As a DSP, I will assist the people I support to direct the course of their own lives.   I will;
  - Work in partnership with others to support individuals leading self-directed lives.
  - Honor the individual's right to assume risk in an informed manner.
  - Recognize that each individual has potential for lifelong learning and growth.

H. Self-Determination

As a DSP, I will assist the people I support to direct the course of their own lives. As a DSP, I will;

Work in partnership with others to support individuals leading self-directed lives.

Honor the individual's right to assume risk in an informed manner.

Recognize that each individual has potential for lifelong learning and growth.

Advocacy

- As a DSP, I will advocate with the people I support for justice, inclusion, and full community participation. I will;
  - Support individuals to speak for themselves.
  - Represent the best interests of people who cannot speak for themselves.
  - Advocate for laws, policies, and supports that promote justice and inclusion for people with disabilities.
  - Promote human, legal, and civil rights of all people and assist others to understand these rights.
  - Recognize that those who victimize people with disabilities either criminally or civilly must be held accountable for their actions.
  - Find additional advocacy services when those that I provide are not sufficient.
  - Consult with people I trust when I am unsure of the appropriate course of action in my advocacy efforts.

I. Advocacy

As a DSP, I will advocate with the people I support for justice, inclusion, and full community participation. As a DSP, I will;

Support individuals to speak for themselves in all matters where my assistance is needed.

Represent the best interests of people who cannot speak for themselves by finding alternative ways of understanding their needs, including gathering information from others who represent their best interests.

Advocate for laws, policies, and supports that promote justice and inclusion for people with disabilities and other groups who have been disempowered.

Promote human, legal, and civil rights of all people and assist others to understand these rights.

Recognize that those who victimize people with disabilities either criminally or civilly must be held accountable for their actions.

Find additional advocacy services when those that I provide are not sufficient.

Consult with people I trust when I am unsure of the appropriate course of action in my advocacy efforts.